STATE OF MONTANA

DEPARTMENT OF LABOR AND INDUSTRY
WORKMEN'S COMPENSATION DIVISION

Report on Review Of Certain Insurance and Disability Compensation Operations

June, 1974

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DEPARTMENT OF LABOR AND INDUSTRY
WORKMEN'S COMPENSATION DIVISION

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Disability Compensation Operations

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DEPARTMENT OF LABOR AND INDUSTRY

WORKMEN'S COMPENSATION DIVISION

APPOINTIVE AND ADMINISTRATIVE OFFICIALS
(Responsible for Programs and Functions Covered by Our Evaluation)

Lawrence M. Zanto, Administrator (Replaced J. J. Carden, who resigned June 30, 1973)

Kermit D. Bovee, Assistant Administrator (Resigned January 4, 1974)

Andrew J. Kiely, Chief, Administrative Bureau

C. Jerry Woods, Chief, Compliance Bureau, Plans I & II

A. G. Pillen, Chief, Insurance Fund Bureau

SUMMARY OF RECOMMENDATIONS

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SUMMARY OF RECOMMENDATIONS (Continued)

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Delivery of Compensation (Continued)

Apply the present worth adjustment to all lump-sum payments as required by Section 92-715, R.C.M. 1947. 131

Take the measures necessary to pay compensation payments through the state claim/warrant system. 133

Agency Organization

Enact legislation to (1) organizationally separate the state insurance program from the present Workmen's Compensation Division and establish it as a separate entity within the Department of Labor and Industry, and (2) vest the remaining organizational units of the Workmen's Compensation Division with the power, authority, and responsibility to administer and enforce the workmen's compensation laws. 141

MORRIS L. BRUSETT, C.P.A.
LEGISLATIVE AUDITOR

Joseph J. Calnan, CIA
~~C. DEAN REED, C.P.A.~~
DEPUTY LEGISLATIVE AUDITOR

STATE OF MONTANA

Office of the Legislative Auditor

STATE CAPITOL
HELENA, MONTANA 59601
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The Legislative Audit Committee
of the Montana State Legislature:

We have reviewed certain aspects of the insurance and disability compensation operations of the Workmen's Compensation Division of the State Department of Labor and Industry. Our review concentrated on the procedures and processes used by the Workmen's Compensation Division in the administration of the state workmen's compensation laws and the State Industrial Insurance program. Although our review encompassed many aspects of the Workmen's Compensation Division operations, it was primarily focused on disability compensation procedures, particularly in the area of claims paid during the period of January 1, 1970, through June 30, 1973. In this respect, our review did not include procedures and processes associated with routine medical benefits, weekly compensation benefits, occupational disease, second injury, volunteer fireman compensation, silicosis program, vocational rehabilitation, and the safety program. In addition, we did not evaluate the actuarial soundness of the State Industrial Insurance Carrier.

Our review, which commenced in July, 1973, was preceded by a limited audit performed by the State Department of Administration which was dated July 23, 1973. Our review was undertaken subsequent to the Department of Administration audit because of unresolved issues and controversy surrounding the workmen's compensation program.

During the course of our review, several areas of possible penal violations were noted and referred to the Attorney General pursuant to Section 79-2308, R.C.M. 1947. These matters are currently under investigation by the Attorney General. Details of these findings are not included here because the investigation is still in progress. However, the results of the audit work completed to date, except for those details referred to above, are presented in this report so as to enable the Select Committee on Workmen's Compensation of the Legislative Assembly to proceed with the study mandated by Senate Joint Resolution No. 70.

Audit work is continuing in other areas of the Workmen's Compensation Division. Expansion of this audit work may be necessary depending on the results of the audit and the investigation by the Attorney General. The results of this work and the investigative effort will be presented in a supplemental report at a later date.

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GENERAL COMMENTS

ORIGINS OF WORKMEN'S COMPENSATION

Prior to 1910, almost the entire body of law pertaining to employer responsibility for industrial injuries was based upon the pre-industrial period in England and the United States. The premise at that time was that employers had no inherent responsibility for injured workers and that the injured workers' only recourse was through the courts where his chances of any recovery were slight. A 1973 document (Compendium On Workmen's Compensation published by the National Commission on State Workmen's Compensation Laws) indicates that during that period not more than 15 percent of injured workers ever recovered damages even though 70 percent of the injuries were estimated to have been related to working conditions or employer negligence.

Under the common law existing at that time, the injured worker had to sue the employer. As a plaintiff, the injured worker had to prove in court that the employer was negligent. The proof was often unreasonably difficult to establish in that it automatically meant the engagement of an attorney and formal court proceedings, both of which an unemployed and injured workman could not afford. The problem was compounded by the fact that fellow workers were usually the sole witnesses and they were reluctant to testify against their employer. Consequently, the injured worker often faced almost insurmountable obstacles in pursuing an injury claim.

According to the Compendium on Workmen's Compensation, the movement for more just laws to replace the old common law began in Europe during the 19th century. The new laws advocated a principle providing indemnity for workman injury regardless of personal fault, employer negligence, or the other common law concepts.

The development of modern industrial insurance laws in the United States lagged far behind Europe. The Compendium on Workmen's Compensation indicates that initially modern industrial insurance laws were supported by employers but opposed by labor interests. Employers were faced with establishing private compensation and relief programs and soon realized that such programs were too costly for small employers and did not provide an adequate solution to the problem of industrial injuries. Labor organizations initially opposed new legislation because of concern that it might represent an infringement upon the prerogative of unions which were growing then. Shortly after the turn of the century, labor organizations shifted their position and began to work actively for progressive industrial insurance legislation.

In 1908 the first real industrial insurance law was passed by Congress covering federal employees. No states had yet passed meaningful legislation. In 1909, Montana passed an industrial insurance law pertaining to miners and laborers in coal mines. This law was subsequently declared unconstitutional as were similar laws in other states on the basis that a compulsory law constituted deprivation of property without due process of law. The first state industrial insurance law to pass and remain effective was enacted in Wisconsin in 1911. Numerous other state laws followed, particularly after 1917 when the U. S. Supreme Court ruled that compulsory compensation laws were constitutional. Montana's law was enacted in 1915. Today industrial insurance compensation acts exist in 50 states, the District of Columbia, and Puerto Rico. In addition, federal laws prescribe coverage for federal employees, railroad employees, and maritime workers.

The types of laws range from compulsory-comprehensive laws to elective-selective laws. Some state laws require all employers to have industrial insurance coverage, while the laws in other states, such as Montana, have

certain exceptions such as self-employed individuals, domestic and casual employer/employees who can elect to have coverage. Still other states, such as New Mexico, have laws which are purely elective to all employments. Nevertheless, workmen's compensation insurance laws are almost universal. A breakdown of the various workmen's compensation laws in the United States is shown on Exhibit B on page 145.

Originally, modern workmen's compensation processes were intended to be self-administering on the basis of a no-fault principle. Liability for industrial injuries was accepted by employers without fault and appropriate payments made. Costs associated with these injuries were absorbed by the employer and borne as a cost of production without any presumption of blame for each and every injury. It is becoming evident, however, that the original simple concept of workmen's compensation insurance has become increasingly complicated. According to the Compendium on Workmen's Compensation, workmen's compensation has failed to achieve certain of its original objectives. The programs have not been self-administering but have spurred litigation. Benefits have increased but generally have not kept pace with rising wage levels. The failure of state workmen's compensation laws to readily adapt and respond has resulted in much criticism which in turn resulted in the formation of a National Commission on State Workmen's Compensation Laws.

The National Commission on State Workmen's Compensation Laws represented the first major involvement of the Federal Government in state workmen's compensation affairs. It evolved from the Federal Occupational Safety and Health Act of 1970 and represents the first major federal intrusion into state workmen's compensation affairs. Unlike most other areas of state operations, workmen's compensation has been and still is relatively free of federal requirements and constraints. However, the National Commission

on State Compensation Laws was charged by federal law with undertaking ". . . a comprehensive study on evaluation of state workmen's compensation laws in order to determine if such laws provide an adequate, prompt, and equitable system of compensation." In accordance with the Federal Act, the national commission evaluated the need for workmen's compensation insurance and the adequacy of the workmen's compensation programs in the various states.

The national commission's evaluation resulted in an extensive formal report issued on July 31, 1972, and several supplementary reports, including the Compendium on Workmen's Compensation, which is a comprehensive review of the issues and information concerning workmen's compensation. The major conclusion reached by the national commission is that state workmen's compensation laws in general were inadequate and inequitable. To rectify these inadequacies, the national commission formulated over 80 recommendations for improvement. Nineteen of the recommendations represent essential elements of a modern workmen's compensation program. Prior to the 1973 legislative session, Montana met only four of the 19 recommended criteria promulgated by the national commission. As a result of legislation enacted in 1973, Montana now meets 14 of the 19 recommendations and is among the leading states in this respect. The specific recommendations and the extent to which Montana has implemented them are depicted on Exhibit A on page 143.

No state has implemented all 19 recommendations. The following table shows where Montana stands in comparison to other states in implementing the 19 recommendations.

STATES WHICH HAVE IMPLEMENTED

15 Recommendations	14 Recommendations	13 Recommendations
1. New Hampshire	1. Hawaii	1. Arizona
	2. Iowa	2. District of Columbia
	3. MONTANA	3. Maryland
	4. Ohio	4. Michigan
	5. Utah	5. Minnesota
		6. Nebraska
		7. Nevada
		8. Oregon
		9. Pennsylvania

Source: Compilation as of September 30, 1973, by U.S. Department of Labor Employment Standards Administration.

HISTORY IN MONTANA

As previously mentioned, an industrial insurance law was first enacted in Montana in 1909 covering laborers and miners in coal mines. However, this law was subsequently declared unconstitutional and, as a consequence, Montana did not have industrial insurance laws until 1915. Chapter 96, Laws of 1915, established an industrial insurance program to be administered by a newly created agency known as the Industrial Accident Board.

The Industrial Accident Board consisted of three members, two of whom were members ex officio by virtue of the fact that they were appointed officers of the Department of Labor and Industry and the Division of Vocational Rehabilitation. The third member was appointed by the Governor and served as chairman of the Industrial Accident Board and executive director of the agency.

The organization and statutes underlying the operation of the Industrial Accident Board remained virtually unchanged for over 50 years. In 1971, the Executive Reorganization Act, Chapter 272, Laws of 1971, abolished the Industrial Accident Board, created the Workmen's Compensation Division, and allocated the division to the Department of Labor and Industry for administrative purposes only. The provisions of the Executive Reorganization Act were implemented on December 13, 1971, pursuant to the Governor's Executive Reorganization Order 11-71.

The changes brought about by the reorganization were for the most part superficial in nature with one exception. In dissolving the membership of the former board, the Executive Reorganization Act provided for a single administrator who assumed the authority previously shared by the board members. The chairman of the former board continued as administrator of the newly created division. His duties in this capacity did not change except for the fact that his actions as chairman of the board previously required the approval of the other members of the board, an action which was nothing more than a mere formality. In actuality, the administrator exercises basically the same authority as he did when he was chairman.

Although the Executive Reorganization Act affected the external organization of the division, the underlying laws remained basically unchanged until 1973. In 1973, major changes were made in the workmen's compensation laws. For the most part, these changes were made, as previously mentioned, in response to the recommendations of the National Commission on State Workmen's Compensation Laws. The most significant change made by the 1973 Legislative Assembly was the provision requiring compulsory-comprehensive workmen's compensation insurance coverage. Wherein the law previously required

coverage only in hazardous occupations and coal mining, the 1973 amendment required that almost all employers, including agricultural employers, have workmen's compensation insurance. The only exceptions now allowed under the law are household and casual employment, members of an employer's family, and the sole proprietors or working members of a partnership. However, employers in these categories can elect to be covered.

TYPE OF WORKMEN'S COMPENSATION INSURANCE

Since enactment in 1915, the Montana Workmen's Compensation Act has provided for three methods by which employers may obtain industrial accident insurance. These methods are referred to as Plan I, Plan II, and Plan III. Plan I is the self-insurer plan, which may be adopted by an employer only if he furnishes sufficient proof to the division of his financial ability to pay all benefits provided by the Act. As of June 30, 1973, there were 71 self-insured employers in the state.

Plan II provides for insurance by a casualty insurance company authorized by the State Insurance Commissioner to sell workmen's compensation insurance in Montana. As of June 30, 1973, there were 144 insurance companies authorized to sell such insurance, and they insured 8,243 employers.

Plan III is the state compensation insurance program which is operated and administered directly by the division. Under Section 92-206, R.C.M. 1947, all public corporations, as defined by section 92-434, R.C.M. 1947, such as state agencies, counties, cities, and towns must insure under Plan III. Any private employer wishing to do so may also request coverage under the State insurance program as opposed to Plans I or II. The division is obligated, by law, to insure any employer requesting such coverage, regardless of the accident record of the employer and the risk involved. As of June 30, 1973, approximately 8,173 employers were covered under Plan III.

OPERATIONS AND FINANCING

Although workmen's compensation insurance is available in three forms, the division retains exclusive responsibility for the administration of the state workmen's compensation laws which govern self-insurers, insurance companies, and the state compensation program. As a consequence, the division is authorized to regulate and control in every respect, the workmen's compensation benefits provided under all three plans.

The operations of the division during fiscal year 1972-73, with respect to each plan, are depicted in the following table:

	Plan I	Plan II	Plan III
Employers Enrolled	71	8,243	8,173
Gross Annual Payroll	$191,416,246	--	--
Gross Annual Premium	--	$9,807,059	$9,475,148
Work Injuries Reported	3,216	11,366	9,239
Claims Filed	729	1,825	1,578
Occupational Disease Cases Reported	3	2	1
Compensation Benefits Paid	$ 910,991	$3,199,444	$4,417,333
Hospital, Medical & Burial Benefits Paid	$ 669,130	$2,427,718	$1,724,685
Subsequent Injury Contributions	$ 500	$ 6,500	$ 3,500

Source: Unaudited data from Workmen's Compensation Division report - Work Injuries in Montana, dated December 31, 1973.

The operations of the division are categorized into basically seven programs for budgeting and financing purposes. These programs and relative level of expenditure during the 1972-73 fiscal year are depicted in the following table, with more detailed information for several years presented in Exhibit C on page 146.

Program	Expenditures 1972-73
Administration	$ 868,752
State Fund Bureau	7,545,941
Silicosis	621,358
OSHA Safety	150,922
OSHA Statistics	34,280
OSHA Occupations Health	25,336
OSHA Mining	21,957
Total Expenditures	$9,268,546

Source: Unaudited data from SBAS report - Form 641, dated 7/19/73.

The division operates out of eight treasury accounts, including the General Fund. Legislative appropriations are made from the General Fund, Earmarked Revenue, and Federal and Private Revenue Fund, while benefits are paid from the Agency Fund. The General Fund appropriation is used exclusively in the silicosis program which receives money from no other source. The financing of division operations during the 1972-73 fiscal year is shown in the following table, with similar data for several years depicted in Exhibit C on page 146.

Source	Expenditures 1972-73
General Fund	$ 621,358
Earmarked Revenue Fund:	
Administration Account	1,007,062
Loss Adjustment Account	661,761
Volunteer Firemen's Compensation Account	7,850
Federal and Private Revenue Fund:	
Occupational Safety Account	150,922
OSHA Statistics Account	34,280
WCD Health Study	25,336
OSHA Mining	21,957
Agency Fund:	
Occupational Disease Account	1,053
Industrial Insurance Account	6,736,967
Total Expenditures	$9,268,546

Source: Unaudited data from SBAS report - Form 641, dated 7/19/73.

ORGANIZATION AND STAFFING

As previously mentioned, the 1971 Executive Reorganization Act allocated the division to the Department of Labor and Industry for administrative purposes only. This means the division is nearly completely autonomous and that is how the division has functioned. Except for the fact that budget requests are submitted by the division through the Department of Labor and Industry, the department exercises no supervision or control over the division. Legislation (H.B. 294) was proposed during the 1973 legislative session to fully transfer the operations of the division to the Department of Labor and Industry. The proposed legislation was not acted upon and was held over to the 1974 legislative session, where it was considered but no action was

taken. If enacted, this legislation would have resulted in a major modification of the division and the department, the organization of which is depicted on Exhibits D and E on pages 147 and 148.

The division is organizationally divided into three bureaus although in operation it is difficult to distinguish the organizational elements. Many of the people employed in the division have multiple responsibilities and work in two or more areas. Consequently, the actual organization in operation is somewhat different from the charted organization shown on Exhibit E on page 148.

As of December 31, 1973, the division employed 115 personnel.

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INSURANCE COVERAGE

In Montana, prior to July 1, 1973, workmen's compensation insurance was compulsory for only employers in hazardous industries and public agencies. The hazardous industries required to be covered were enumerated in the law along with a general provision that any other inherently hazardous occupations were also required to be covered by workmen's compensation insurance. All other employers not included in the compulsory requirement could elect to be covered if they so desired.

The 1973 legislature made substantial changes on compulsory coverage. The sections of law pertaining to hazardous industries were repealed (Section 6, Chapter 443, Laws of 1973) and new legislation was enacted making workmen's compensation insurance compulsory as of July 1, 1973, for all employers except the following:

1. Household employment.
2. Casual employment.
3. Employment of members of an employer's family dwelling in his household.
4. Employment of sole proprietors or working members of a partnership.
5. Employment for which a rule of liability for injury, occupational disease, or death is provided under Federal law.
6. Persons performing services in return for aid or sustenance only.

Although employers in the foregoing categories are not subject to compulsory coverage, they can elect to participate in the workmen's compensation insurance program.

Employers have three avenues of obtaining workmen's compensation insurance. Subject to the approval of the division, employers can self-insure (referred to as Plan I), purchase insurance commercially (referred to as

Plan II), or insure with the state insurance fund (referred to as Plan III) operated by the division. If an employer fails to provide workmen's compensation insurance, two general situations arise: (1) the employer has violated the provision of law which requires coverage, and (2) the intent and purpose of a compulsory law are obviated by virtue of the fact the burden associated with an industrial injury is placed fully upon the injured employee.

If an employer fails to provide workmen's compensation insurance as required by law, the injured employee finds himself in one of the following situations or a combination thereof.

1. The employer might pay the medical bills and the employee will lose wages due to time off the job. In this case, the employer has lost all benefits provided by an insurance program, i.e., sharing the risk, and the employee has lost wages.
2. The employer might pay the medical bills and continue to pay the employee without the benefit of his services. This puts the employer in the position of being self-insured and unless the employer has considerable assets, both the employer and employee will suffer if the employer's business fails financially.
3. The employee will have to sue his employer for payment of medical bills and lost pay. When the employer-employee relationship reaches this stage, an adversary relationship ensues and there is a good chance the employee will lose his job whether or not the lawsuit is successful. As a consequence, the principle underlying workmen's compensation insurance--liability without fault--is obviated.

ENROLLMENT OF EMPLOYERS

Our review disclosed that the division has no effective means of assuring that all employers have workmen's compensation, as required by law. As a

consequence, many employers do not have workmen's compensation insurance and an indeterminate number of employees have no coverage against the costs associated with industrial injuries.

As a matter of routine practice, the division provides workmen's compensation insurance to employers who apply for coverage but does not seek out employers who have no coverage, even though the requirement for coverage is compulsory and the division is the sole agency responsible for assuring compliance with the law. The Montana Supreme Court has recognized certain affirmative duties placed on the division, and in discussing the duties of the Industrial Accident Board, the division's predecessor, the court stated in Miller v Aetna Life Ins. Co., 101 Mont. 212, 220; 53 p 2d 704 (1936):

> "'The Workmen's Compensation Act was enacted for the benefit of the employee.' The correctness of this conclusion is universally conceded and the vital part of the machinery set up by the law to carry the provisions of the Act into effect is the Industrial Accident Board. The board is a state board and we think the Act implies that its first duty is to administer the Act so as to give the employee the greatest possible protection consistent with the purposes of the Act."

To see that employees receive the greatest possible protection under the act, it is necessary that the division make a substantial effort to insure that all employees have workmen's compensation coverage as required by law.

There are a number of means readily available to the division through which comprehensive coverage could be advanced. These means are as follows:

Employment Security Division

The Employment Security Division (ESD) and the division are somewhat related in that both are divisions of the State Department of Labor and Industry.

As a matter of routine practice, the ESD provides the division with a monthly list of new employers added to the ESD rolls. This list is

developed by the ESD through new enrollments, field examinations, and comparison to Federal Social Security Administration and State Department of Revenue reports. Although the ESD list is sent to the division monthly, it is not used by the division.

As a means of determining the extent to which employers are not covered by the division, we compared employer names with the data maintained by ESD. Employers were sampled from over 18,000 employers registered with the ESD. We compared the employers sampled to records maintained by the division and found that 14.2 percent of the employers had no workmen's compensation insurance, even though such insurance is compulsory by law. We verified the absence of workmen's compensation insurance directly with the employers, thereby corroborating the sample results.

Projection of the rate of 14.2 percent to the over 18,000 employers registered with ESD who are subject to coverage by workmen's compensation insurance, indicates that 2,590 employers in the state registered with ESD do not have workmen's compensation insurance as required by law. Because of the manner in which sample techniques are used, this projection can technically range between 1,390 and 3,790 employers; however, the chances are great that about 2,590 employers registered with ESD do not have the required insurance.

The results of the projection may be conservative because the ESD list of employers does not include three large categories of employers covered by the compulsory workmen's compensation laws. These employer groups and estimated number of employers are as follows:

Category	Number of Employers
1. Agricultural	16,000
2. City, County, and State Government	750
3. Real estate and insurance companies paying employees on a commission basis	unknown
Minimum Total	16,750

Irrespective of the exact numbers involved, comparison of ESD and division records indicates that substantial numbers of employers have not obtained workmen's compensation insurance coverage for their employees. Similar indications are evident from analysis of records maintained by the Safety Bureau of the division.

Safety Bureau

The Safety Bureau of the Workmen's Compensation Division conducts periodic inspections of Montana firms for compliance with federal and state safety rules and regulations. Because of the manner in which costs are distributed within the bureau, inspectors maintain records showing which workmen's compensation insurance plan the employers are covered under, i.e., Plan I, Plan II, or Plan III.

In the course of their visits to businesses, the inspectors occasionally discover that firms do not have workmen's compensation insurance. The names of these employers are orally communicated to the division's Underwriting Section for follow-up and enrollment. Upon receiving this information from the Safety Bureau, we were advised that the Underwriting Section determines whether the employer is exempt from the compulsory law and, if not, sends an application to the firm for enrollment in Plan III.

Once the application for enrollment is mailed, no follow-up or correlation is made by the division to insure that workmen's compensation insurance is obtained by the employer. For example, from July 1, 1973, to December 28, 1973, the Safety Bureau provided the names of 29 employers to the

Underwriting Section. Enrollment applications were sent to six of the employers, and our analysis showed that only one firm subsequently enrolled. The remaining 23 were a combination of hazardous and non-hazardous employers and were not contacted. One of these 23 employers is a post and lumber firm that has been in business for four years and presently employs 35 people with no workmen's compensation insurance. The remaining 22 employers were not enrolled and consequently have no workmen's compensation insurance. The division is presently following up on the remaining cases.

Cancelled Firms

Frequently employers covered by Plan II and Plan III become delinquent in their payment of insurance premiums and, after a grace period, are cancelled from coverage by the insurer or the division. The division does not follow up on these employers to see if the employer (1) is out of business, (2) has switched to another plan, or (3) is operating without workmen's compensation insurance in violation of the law. During fiscal year 1972-73, 1,235 employers cancelled coverage from Plan II and Plan III coverage for the following reasons:

Reason for Cancellation	Number of Firms Cancelled	
	Plan II	Plan III
Failure to pay premiums	71	222
Non-renewal	280	0
Request of insurance carrier or employer	145	0
Failure to secure forms	11	0
Change in ownership	377	15
Other	76	38
Total	960	275

As previously mentioned, the workmen's compensation law in Montana is compulsory. That is, employers must have workmen's compensation insurance. On this basis, cancellation of coverage by the division for any reason defeats the purpose of the compulsory law. In those instances where coverage has lapsed for any reason, the division should take appropriate measures to determine whether the employer has gone out of business or switched to another plan. Where neither of the foregoing has occurred, the division should take whatever action is appropriate to reinstate coverage, including legal measures if necessary.

The significance of the absence of follow-up is illustrated by our test of seven employers who were cancelled from Plan III coverage on October 18, 1973. We found that three of the seven employers are currently operating without workmen's compensation insurance even though coverage for them is compulsory. One of these employers is a painting contractor who, at various times, has up to 15 employees and has been in business for two years. Division personnel said they were unaware of the fact that this employer was not covered by workmen's compensation insurance as required by law.

Medical Bills

The division routinely receives medical bills from hospitals, doctors, and druggists that must be researched to determine coverage and propriety of payment. Research of these bills often discloses that the employer has no workmen's compensation insurance. From September 4 to November 5, 1973, there were 226 such cases.

The bills upon which no coverage has been determined end up in a basket labeled "no coverage." On occasion, the executive secretary reviews these cases; those with coverage are processed, and those without coverage are returned to the physician. We reviewed 20 of these cases and found: (1) 13 of the cases were for employees that were covered even though the division had concluded that there was no coverage, (2) one bill represented a claim for a federal employee who was not entitled to coverage by the state, and (3) six of the bills were for employees of firms that were not covered but should have been.

One employee was injured in a logging accident in September, 1973. He was hospitalized for four days with medical bills totaling $987. The employer stated that he felt the courts would hold him liable for the injury; therefore, he paid the medical bills. He also stated he gave the employee a job as relief driver, although he really was not capable of productive work. The

employer has subsequently applied for and received coverage under Plan III on November 28, 1973.

The facts illustrated by the foregoing are that the division does not have an effective means of assuring that employers have workmen's compensation insurance as required by law and that, as a consequence, a significant number of employers and employees are without workmen's compensation insurance.

RECOMMENDATION

We recommend that the division:

1. *Consult with the Employment Security Division to devise a mechanical means of preparing an exception list of employers registered with one agency but not the other.*
2. *Establish routine procedures for the follow-up and enrollment of employers identified by:*
   (a) Comparison to Employment Security Division records.
   (b) Safety Bureau inspections.
   (c) Cancellation due to delinquent premiums.
   (d) Research of medical claims.

APPLICATION OF PENALTIES

Workmen's compensation coverage in Montana became compulsory in 1973. All employers are required to have workmen's compensation insurance except the six categories of employers specified in Section 92-202.1, R.C.M. 1947. All other employers must have coverage. Section 92-207.1, R.C.M. 1947, specifies that employers failing to have industrial insurance coverage as required by law:

> ". . . shall be guilty of a misdemeanor, and punishable by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600) or imprisonment in the county jail for a period not to exceed six (6) months or by both such fine and imprisonment. A failure to provide compensation for each employee shall be deemed a separate offense for the purposes of this act."

The language of the foregoing statute is mandatory and has been in effect since 1941 for hazardous industries and, since 1973, applies to most other occupations. An employer without the workmen's compensation insurance required by law may be found guilty of a misdemeanor and subject to a mandatory fine and/or imprisonment. The statutory requirements are in no way discretionary. The division has no authority to do anything but seek application of the penalties provided by law for those employers who refuse to obtain coverage. Nevertheless, the division does not, and has never, insofar as we could determine, attempted to seek enforcement of the provisions of this statute.

As previously mentioned, the division does not have an effective means of assuring the employers have workmen's compensation coverage. In those instances where uninsured employers are identified, the division merely sends the employers an application for enrollment. In those instances where a claim is presented by an injured employee of an uninsured employer, the division returns the claim to the employee with a form letter advising the employee that his claim is invalid since the employer had no coverage. This leaves the injured employee with no alternative but to drop the claim or pursue collection from his employer.

In the event the employee decides to sue his employer, the workmen's compensation laws provide some favor towards the employee. Section 92-201, R.C.M. 1947, specifies that the common-law defenses ordinarily available to an employer (i.e., assumed risk of employment, fellow-servant negligence, and contributory negligence) are not available to the uninsured employer. As a consequence, the employee has a greater chance of a successful lawsuit. Yet, the necessity of going to court against his employer, the associated costs, and the risk of losing his job, are direct contraventions of the entire

purpose of workmen's compensation laws. The law requires the employer to be insured and when the employer is not insured, it is the injured employee who is penalized due to an act of omission by the employer. That this is true is underscored by the provisions of Section 92-211, R.C.M. 1947, which specifically stipulate that:

> "No compensation shall be paid to any employee, . . . where his employer has failed to elect, and has failed to come under one or the other of the compensation plans herein provided."

The Compendium on Workmen's Compensation Laws states that only a few states have anticipated the acute problems faced by an injured worker whose employer is uninsured. Only nine states have arrangements for paying the claims of injured employees who are unable to collect compensation from non-complying employers. According to the Compendium, the state insurance carrier in North Dakota, Ohio, and Oregon assumes the responsibility and pays the employee. In Arizona, Connecticut, Maryland, Minnesota, New Jersey, and New York, such claims are paid out of a special compensation fund. In Montana the employee has to sue the employer.

A special compensation fund, financed by assessments on all employers, would provide an equitable means of providing benefits to the injured employees who, through no fault of their own, are not entitled to benefits because their employer failed to obtain workmen's compensation insurance.

The present practice and statutes, specifically Section 92-211, R.C.M. 1947, should allow the injured employees of uninsured employers to have an option to one of the following recourses:

1. Suit against the employer with employer common-law defenses abrogated, as is now provided for by Section 92-201, R.C.M. 1947.

2. Payment of medical and disability compensation from a special compensation fund, funded by assessments to all three plans, with subrogation of the employee's interests to the state.

In the second option, the medical and disability compensation benefits due the injured employee should be paid as if the employer had been enrolled. In such instances, the statutes should provide that the injured employee's rights and privileges are subrogated to the state, in which case the division should seek action against the employer to recover the cost of the compensation paid the injured employee in addition to the penalties and fines provided for by law.

Modifications of the statutes in the foregoing manner would be consistent with Section 92-1116, R.C.M. 1947, which presently permits such an option to injured employees of employers who have defaulted in payment of Plan III premiums. Similar authority should apply to all employers who do not have coverage.

RECOMMENDATION

We recommend that the division:

1. *Seek application of the penalties required by Section 92-207.1, R.C.M. 1947, against all employers who refuse to obtain workmen's compensation insurance.*
2. *Seek the legislation necessary to:*
   (a) Repeal the provisions of Section 92-211, R.C.M. 1947.
   (b) Establish a special compensation fund for payments to uninsured employees to be funded by assessments to all three plans.

(c) Allow injured employees of uninsured employers the option of suit against their employer or compensation from the special compensation fund.

(d) Allow the division to pay medical and disability compensation at the option of the injured employee in exchange for the right to subrogation of the employee's interests.

(e) Allow the division to undertake actions against uninsured employers to recover the costs of the compensation paid to the injured employees.

RATES AND PREMIUMS

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RATES AND PREMIUMS

An employer buys workmen's compensation insurance based on the type of work performed by his company. There are different rates of premiums for employers in different industries or work classifications. For example, in Plan III a retail department store pays a rate of $0.70 per $100 of payroll, while a concrete ready-mix dealer pays a rate of $3.55 per $100 of payroll. If the concrete ready-mix dealer has an annual payroll of $100,000, his premium equals $3.55 x 1,000 or $3,550 per year. A rate then, is the unit of premiums for each $100 of payroll for a particular work classification.

There are rates for two of the three types of workmen's compensation insurance plans available to the employer. Plan I is the self-insured employer. Inasmuch as Plan I employers are self-insured, they have no rate, and consequently pay no premium. The Administrative Bureau of the division is responsible for reviewing the "Proof of Solvency" filed by self-insured employers to assure that they have the financial ability to pay any claims by employees that may arise. Plans II and III rates must be filed with and approved by the State Insurance Commissioner according to Sections 40-5609 and 5610, R.C.M. 1947. The Insurance Commissioner reviews the rates to see if they comply with the requirements of the state insurance laws and then keeps them on file.

RATES

Inasmuch as the rates charged by all private carriers (Plan II) are filed with the State Insurance Commissioner and are subject to regulation by the Commissioner, the division has little or no involvement with Plan II rates. Consequently, the following comments primarily pertain to the State insurance program (Plan III).

There are rates for 339 classifications covered by the division, with additional rates available upon request. These rates vary between

occupations because of the different losses (as a result of medical and compensation claims) experienced. For example, the rate for logging is high because of the high accident experience every year in Montana, while the rate for office clerks is relatively low because of low accident experience in the state.

Private insurance companies and many competitive state insurance programs use the rates or a deviation thereof, published by the National Council on Compensation Insurance (NCCI). None of the exclusive (monopoly) state insurance programs use NCCI rates. The NCCI is a non-profit organization begun in 1913 to provide rates for workmen's compensation insurance. NCCI is financed on the basis of the amount of premiums written by members which are private insurance companies and state insurance programs throughout the county.

Montana's state insurance program is a member of NCCI but does not use NCCI rates. Instead, the division formulates and revises its own rates annually with the help of an actuarial firm. These rates are published annually in a manual issued by the division and become effective July 1 each year.

There are 12 states including Montana which have the same type of workmen's compensation insurance plans available to employers, i.e., self-insurance, commercial companies, and state-operated insurance program. These are called competitive state insurance programs because they are competing with private insurance companies for workmen's compensation insurance business. The following table illustrates the method of rate determination used by the 12 competitive state-operated programs.

METHOD OF RATE-SETTING FOR
COMPETITIVE STATE FUNDS

	Use NCCI Rates Or A Percentage Deviation	Use A Statewide Rate-Setting Bureau	Fund Sets Own Rate
Arizona	X		
California		X	
Colorado	X		
Idaho	X		
Maryland			X
Michigan		X(1)	
Montana			X
New York		X	
Oklahoma	X		
Oregon	X		
Pennsylvania		X	
Utah	X		
Total	6	4	2

(1) Statewide rate-setting bureau uses NCCI rates as a basis for their rates.

Source: U.S. Department of Labor Bulletin, No. 317, 1969 - Insurance Arrangements under Workmen's Compensation.

One of the reasons the division sets its own rates is to avoid rate fluctuation. The division has preferred to keep rates relatively static even though loss experience from previous years shows the rate will probably result in a loss of money for the new rate year.

We compared a sample of 55 rates used by the division with NCCI rates to determine the significance of the division's policy on rate fluctuation. The comparison covered a six-year period ranging from fiscal year 1967-68 through 1972-73, and the comparison showed that:

Plan III had the same rate three years in a row on 41 occasions for the 55 rates reviewed, while NCCI rates did not have the same rate three years in a row in any instance and had the same rate two years in a row only once.

The effect of the division's policy is to keep the rates relatively static. This policy creates an inequality to the employers in that some employers are not being charged enough and this is made up by other employers being charged too much. The following examples illustrate the inflexibility of the division's Plan III rates and the inequality of this policy:

	Industry A			Industry B		
Fiscal Year	Plan III Rate	Break Even Rate	Plan III Gain	Plan III Rate	Break Even Rate	Plan III Loss
1967-68	$3.50	$0.99	$149,236.94	$3.25	$4.65	$(34,905.66)
1968-69	3.50	1.37	137,192.80	3.50	3.77	(9,980.82)
1969-70	3.50	2.60	74,889.72	3.50	8.27	(160,165.48)
1970-71	3.50	1.65	179,291.74	3.70	4.73	(45,306.86)
1971-72	3.75	1.18	202,507.63	4.80	7.11	(114,713.87)
1972-73	3.90	0.73	107,303.75	5.80	6.37	(15,570.71)
Total Gain or (Loss)			$850,422.58			$(380,643.40)

For instance, for Industry A, (1) the rates charged by the division for Plan III remained the same for four years in a row; (2) the Plan III rate stayed the same or increased even though the actual loss rate indicated that the Plan III rate was too high.

For Industry B, (1) the rates charged by the division for Plan III remained the same two years in a row; (2) Plan III rates remained the same even though the actual loss rate indicated that the Plan III rate was too low.

In addition to the foregoing, the table also illustrates that one group of employers is subsidizing the other. The employers represented by Industry A paid approximately $850,000 more in premiums during the six-year period than was necessary, while the premiums paid by the employers represented in Industry B were short approximately $380,000. The end result of this is that one group of employers is paying for the losses of another group simply because the rates charged by the division are inflexible and are not responsive to individual classification.

The fact that the foregoing situation is a discriminatory problem was recently expressed by the Commissioner of Insurance in Massachusetts. Mr. John Ryan, Massachusetts Insurance Commissioner, stated (June 1, 1973, Report to Massachusetts Public) that:

> "Rates that call for stevedores to pay more in the way of loss adjustment expense than is needed to meet the expected expenses that will be incurred for their losses are unfairly discriminatory to them."

The discriminatory aspect of the problem is the same under the rate-making practices followed by the Montana State Workmen's Compensation program.

The prime factor in rate-making is the loss incurred, i.e., medical and compensation payments. The losses are continually recorded on the division's computer during the year, and at rate-making time a listing of losses by job classification is printed. This listing reflects only the losses experienced by the division. The losses of Plan II insurers are not compiled by the division and, therefore, are not considered in the Plan III rate-making process.

To establish its rates for Montana, NCCI obtains a computer tape from the division reflecting the loss experienced by the division by classification by employer. NCCI also collects loss data during the year from all Plan II insurers in the state. From this data base, which is twice as large

as that used by Workmen's Compensation Division, NCCI computes the loss factors by classification. To this it adds factors for expenses plus a profit. The rates are published, filed with the State Insurance Commissioner, and sent to all members in Montana, including all Plan II insurance companies and the division. According to officials of the division, the NCCI rates are available and sometimes reviewed but not actually used in their rate-making process.

Because of the technical area of insurance rates, we engaged an actuarial consultant to review, among other areas, the rate-making procedures of the division. In his report, which is included as Exhibit H on page 152, he recommends that the division use NCCI rates, "Because of its vast experience and facilities as well as its access to a larger volume of accurate statistics, the NCCI is better equipped to produce meaningful rates than a private organization."

The method of rate-making used by the division and NCCI also differs from the standpoint of incentives for employer safety. Rates used by the division treat all employers in the same job classification equally from the standpoint that all employers in the same classification have the same rate. In addition, the employers in each job classification share the losses of that industry. This provides some incentive for safety efforts within an industry but, aside from dividends, there is no incentive for individual employers. While dividends do have some incentive to reduce losses, they are based on total losses to all employers.

The data from which the NCCI rates are formulated include loss experience by classification by employer. Employers who have an average premium of $750 for two or more years, or $1,500 of premiums in the most recent year, are "experience rated" by NCCI. Under the concept of experience rating, the employer's premium is reduced or increased, depending upon whether his loss

experience is better or worse than that of the average employer in the same rating with the same size payroll. For example, a large logging firm was faced with a commercial rate of $35.18 per $100 of payroll for purposes of premium computation. The firm was large enough to meet the criteria for experience rating and, as a result, the NCCI's northwest branch in Portland, Oregon had the firm's actual experience data on file. Using this data, the NCCI rating bureau gave the firm an "experience modification" of .66. This means his rate would be $23.33 (66 percent of the normal rate of $35.18) because the firm's loss experience proved that it was a better risk than the average logging firm.

Experience rating gives the employer much more incentive for safety efforts in that his premium is directly related to his losses. We were advised by an NCCI official that about 40 percent of the Plan III employers in Montana qualify for experience rating. This was confirmed by our review of the employers presently enrolled under Plan III.

The appropriateness of experience rating was further established by the actuarial consultant engaged by our office. The actuarial consultant's report, the full text of which is included at Exhibit H on page 152, states that:

> "Private carriers are offering experience rates to qualifying employers. These rates can be higher or lower than the manual rates, depending upon the past experience of the employer. We recommend that the Workmen's Compensation Division offer its employers similar experience rates as established by the NCCI. This approach would:
>
> "(a) Encourage safety in industry by recognizing favorable past experience in the form of premium discount at the beginning of each year.
>
> "(b) Equitably penalize poor past experience on an individual basis rather than on a classification basis. Overcharges, in the event of improved experience, would be adjusted through dividends at the end of each year.

"(c) No additional expenses would be incurred by the Workmen's Compensation Division since experience rating is included in the services provided by the NCCI."

The NCCI rates are only the starting point for most state insurance programs and private insurance companies. There are three ways in which the NCCI rates are further reduced.

1. Use of straight percentage deviation, i.e., each class rate is reduced by the same percentage.

2. Use of volume discounts, i.e., discounts which recognize that as the employer's premium increases, the proportion of the premium required to pay expenses decreases. Most insurers use the following plan of volume discounts:

Amount of Premiums		Percentage Deviation	
		Stock Companies	Mutual Companies
1st	$ 1,000	-0-	-0-
Next	4,000	9.4	3.0
Next	95,000	14.7	6.0
Over	100,000	16.3	8.5

3. The payment of dividends.

Plan III is considered to operate like a mutual carrier because it pays dividends.

The actuarial consultant engaged by our office made the following comments with respect to use of percentage deviation and volume discounts:

"Certain fixed costs are incurred for record-keeping and administrative costs by the Workmen's Compensation Division on all employers covered, whatever their size. Therefore the actual cost per premium dollar decreases as the size of the premium increases. We recommend that the state incorporate a schedule for reducing the charges to employers whose annual premiums exceed specific minimums. The reductions would vary with size of the premiums. Private carriers as well as most state funds offer such reductions to their clients.

"The rates would be in direct proportion to those used by private carriers and would not have the random inconsistencies which now occur. As a result, the rates should be more palatable to everyone, particularly the employers.

"Of each $1.00 of premium determined by the NCCI, approximately 60 cents is needed to pay claims and 40 cents is for expenses. Of the 40 cents, 17.5 cents is for acquisition costs and 2.5 cents is for profits. These two expenses are a necessary operational cost of private carriers, but not of the Workmen's Compensation Division. It is on this basis that the uniform reduction of 20% is suggested. If the premium is not reduced, an adjustment should be made at the end of the year through a larger dividend. The advantage of a reduced premium is that the employer will not be required to invest as much working capital during the year only to have it refunded at the end of the year." (See Exhibit H on page 152.)

In 1969, Section 92-1105, R.C.M. 1947, was amended to require that the division be a member of a rating organization and ". . . shall take advantage of the experience and information afforded to it as a member of such rating organization." The division joined the NCCI in 1970 and has been a member since that time at a total cost of $44,325. In return, the division has sought and received very limited services--copies of the NCCI manual, inspection of six employers each year for correct job classification, and free use of a Watts telephone line to NCCI's northwest branch office. The division has not used the full services and experience of NCCI; namely, rates, experience rating service, and volume discount.

During the four-year period in which the division has belonged to NCCI, the division engaged an actuarial firm to assist with the rate-making process at a cost of $24,537. Most of this cost would not have been necessary if the NCCI rate-making process had been used.

The division should implement rate-making processes which are responsive to actual experience and include individual firm experience ratings and volume discounts. This could be accomplished through full utilization of the services offered by NCCI or independently by the division without the services of NCCI. To do so independently would require more sophisticated procedures and would also require more extensive actuarial services. Consequently, the division should examine the cost of performing this service internally in terms of the benefits to be derived in contrast to full utilization of NCCI.

RECOMMENDATION

We recommend that the division:

1. *Establish rate-making processes which:*
   a) *Respond more promptly to industry loss experience.*
   b) *Incorporate experience rating procedures, and*
   c) *Provide for volume discounts.*
2. *Examine the possibility of greater use of NCCI to establish more equitable and responsive rate-making processes for the state insurance program.*

PREMIUMS

As previously explained, premiums are the amounts which the employers pay for workmen's compensation protection and are computed on the basis of payroll and premium reports submitted by employers. The report is sent to employers by the state insurance program. When sent out by the state insurance program, the report is blank except for the employer's class and rate. The employer inserts his payroll for the reporting period, computes the premium, and submits payment to the state insurance program along with the payroll and premium report.

Premiums are due on the 15th of the month after the payroll and premium report is sent out by the state insurance program. If the report is returned with partial or no payment, the premium becomes a premium due. After varying lengths of time, the defaulting employer is notified that cancellation procedures have begun. If payment is still not received, the employer is cancelled and no longer has Plan III workmen's compensation insurance coverage.

Plan III operates on a non-profit basis and any surplus of Plan III income over expenses and reserve increases is returned annually to eligible Plan III employers in the form of a dividend. Plan III employers who have paid in excess of $40 in premiums and had a loss ratio of 85 percent or less during the fiscal year are eligible for dividends. The amount of the dividend paid to each employer is dependent upon (1) the amount of income after expenses, (2) the amount of premiums paid by the employer, and (3) the amount of losses incurred by the employer.

Adjustment of Initial Deposits

Under present procedures an employer is required to make an initial deposit before his coverage is effective. The amount of the deposit is usually not changed by the state insurance program for the duration of the employer's coverage. However, two of the three factors affecting the calculation of the initial deposit will normally change each year, i.e., annual payroll and rate. The state insurance program manual provides that "the initial deposit premium is that amount required as a cash security for each risk and is subject to periodic adjustment at the discretion of the Division of Workmen's Compensation."

Failure to periodically review and adjust initial deposits can result in two conditions - inadequate or excess initial deposits. Both of these situations were found during the course of our review.

For example, a logging firm applied for coverage in 1970, with an estimated annual payroll of $15,000 and was required to pay an initial deposit of $692. During 1971, the firm submitted payroll and premium reports with gross annual payroll of $210,000 - a 1,400% increase. If this firm's initial deposit would have been adjusted by the payroll increase at the 1971 rate for logging, the deposit would have been $10,430. Therefore, the initial deposit

account was short $9,738. In 1972, this firm was cancelled for failing to pay premiums, and on April 20, 1973, premiums due of $17,035 were written off as an uncollectible debt. If the state insurance program had made periodic adjustments to initial deposits, the uncollectible amount would have been reduced to $7,297.

In July, 1973, the Department of Administration recommended that the state insurance program "Limit initial deposits to no more than $5,000" and "Generally not require initial deposits from firms owing less than $100 a year." These recommendations have since been implemented by the state insurance program but were not in effect in early 1973 when the premiums due from the logging company were written off. Had the state insurance program made periodic adjustments as it should have, following the Department of Administration's advice, the $17,035 loss would have been reduced to $12,729.

In another instance, an employer has $1,045 on deposit with the state insurance program at the present time. At his current rate, payroll, and reporting period his deposit should be $30 or zero, according to the Department of Administration's recommendation. In essence, the state insurance program is holding $1,045 more on deposit than it needs to protect its premiums due.

To prevent nuisance increases and decreases in the initial deposit, some percentage and/or amount of deviation should be established to eliminate minor fluctuations and at the same time provide adequate security in initial deposits. For example, we used 25 percent in our review of 19 sample cases. We analyzed 19 employers allowing a deviation of $\pm$ 25 percent in the amount of security deposit. Thirteen of the 19 employers had initial deposits in excess of $\pm$ 25 percent of the amount that should be held by the state insurance

program as security for the risk involved. Eight firms having $2,082 in initial deposits were $16,518 short of having the correct amount, while five firms having $1,520 on deposit should have had $1,480 returned to them.

In a previous audit report on the workmen's compensation program (Office of the Legislative Auditor, 1969) we recommended adjustment of initial deposits but the recommendation has not been implemented. The state insurance program began implementation of computer procedures to adjust initial deposits in 1971, but we were advised that the former division administrator stopped the procedure because he believed that many employers covered by Plan III would be against such a change because it could increase the amount of initial deposits.

Deposits were designed to protect premiums due. They are prescribed by NCCI for private carriers and are used throughout the industry. We agree with this practice and believe there should be no arbitrary limit placed on the amount of deposits because it is an accepted industry practice and because the amounts on deposit bear interest for the employer. Since the NCCI prescribes the level and amount of deposits for all carriers, the state insurance program should also follow the NCCI procedures.

RECOMMENDATION

We recommend that the division:

1. *Establish procedures whereby the levels of initial deposits are allowed to tolerate a uniform percentage of fluctuation in premiums before being adjusted.*
2. *Periodically review the adequacy of all initial deposits and require increased deposits or return excess deposits as the case dictates.*
3. *Follow schedule for initial deposits recommended by the National Council on Compensation Insurance.*

Premium Due Notices

The state insurance program sends an employer's payroll and premium report to employers about the last week of the month for the period in which the premium is due. The employer fills in the amount of the payroll, computes the premium, and submits the report and full payment to the state insurance program by the 15th of the following month. If the employer fails to do this, the state insurance program sends him a reminder referred to as a "premium due notice."

Under current procedures premium due notices are manually prepared only when the payroll and premium report is returned with insufficient or no payment. Premium due notices are not sent to employers who, for various reasons, do not return the payroll and premium report and no follow-up is made. Approximately 200 premium due notices are prepared each month for those employers who submit partial or no payment. At one time the division used the computer to prepare the premium due notices but discontinued this practice because numerous employers that had sent in their premiums were erroneously receiving premium due notices. This resulted because the state insurance program did not verify that the premium was still outstanding at the time premium due notices were mailed.

RECOMMENDATION

We recommend that the division:

1. *Use data processing services to print premium due notices.*
2. *Establish procedures to verify the absence of premium payments just before premium due notices are mailed.*
3. *Design follow-up procedures for premium reports not returned.*

Aging of Premiums Due

Aging is a procedure whereby payments due are scheduled to identify and determine the degree of delinquency of payments.

Aging of premiums due is important because it identifies delinquent payments and provides the basis for cancellation of employers that fail to pay their premiums. The initial deposits provide security against the risk of bad debts for a given period of time, and unless the aging of premium due is correct, the state insurance program cannot establish cancellations within the time frame covered by the initial deposit.

Each month the computer prints a premium due report which contains (1) employers with premiums due, (2) period for which they are due, (3) the date the Premium Due Notice is prepared by the division accounting section, and (4) the premium due aged in terms of days, and other information.

The report is not regularly produced on any particular day of the month and the beginning date of the aging process is the date the payroll and premium report is prepared rather than the 16th day of the month, the day premiums due become delinquent.

Our review of 50 employers from four different premium due reports showed that all premiums due were inaccurately aged because of the manner and dates in which the report was prepared. The errors ranged from four to 119 days. Consequently, the division has inaccurate information upon which employer cancellations are based.

RECOMMENDATION

We recommend that the division:

1. *Establish a specific date for monthly preparation of the premium due report.*
2. *Establish procedures to age premiums due from the end of the grace period through the date of the premium due report.*

Exemptions for Corporate Officers

Prior to July 1, 1973, the division rules stated that the earnings of corporate officers covered by Plan III should have been included in the statement of payroll and premium charged, subject to a maximum individual payroll limit of $15,600 annually. On July 1, 1973, the maximum was administratively changed to $6,000 by the division. This change had the effect of reducing the amount of reportable payroll, and hence reducing the amount of the premiums collected from corporations.

This policy of administratively setting a maximum on the earnings of corporate officers to be included in the statement of payroll and premium charged appears to be contrary to the requirements of the Workmen's Compensation Act. Section 92-1101, R.C.M. 1947, states:

> "Compensation Plan Number Three. Every employer subject to the provisions of compensation plan No. 3 shall at the times and in the manner prescribed by the industrial accident board, pay to the industrial accident board a premium based on a percentage of his payroll as determined by the industrial accident board which shall be a member of a rating organization in accordance with the provisions of this act." (Emphasis supplied)

In computing the payroll, Section 92-1121, R.C.M. 1947, requires that all compensation of every workman must be included, and Section 92-411, R.C.M. 1947, defines workman as including corporate officers. Thus, under the provisions of the Act, it appears that the total salary of corporate officers must be included in the reported payroll of a corporation.

Also, Section 92-411, R.C.M. 1947, provides in part:

> "For premium rate making the insurance carrier shall assume salary or wage of such electing 'employee' (sole proprietor or partner) to be five hundred dollars ($500) per month."

Based upon this code section, the division has collected premiums based upon a payroll including only $500 per month salary, or $6,000 per year, for partners and sole proprietors. However, benefits are paid to partners and

sole proprietors at the full $110 per week statutory maximum which is based upon an annualized salary of $7,920. It would thus appear that sole proprietors and partners are not paying their fair premium share relative to benefits received.

The division has treated corporate officers in the same manner so as not to discriminate against them in comparison to partners and sole proprietors. Statutory authority for this procedure does not exist under the Workmen's Compensation Act.

In addition to the above problem, we contacted five corporations insured by the state insurance program to determine if they were aware of the change in reportable earnings of corporate officers. Two corporations were aware of the $15,600 limitation and were excluding the wages over that but were not aware of the $6,000 limitation. One corporation was not aware of the $15,600 limitation and therefore was not excluding anything. The other two corporations had exercised the elections to exclude corporate officers from workmen's compensation insurance coverage; however, they were not aware of the $6,000 limitation. Based on the foregoing, it is obvious that many employers do not know about the new limitation on corporate officer earnings and are paying more than necessary.

RECOMMENDATION

We recommend that the division:

1. *Comply with present statutory requirements for computing payroll for sole proprietor, partners, and corporate officers, or seek legislation which specifically limits or authorizes the division to limit maximum payroll for such individuals.*

2. *Establish procedures to insure that all changes are uniformly communicated to employers as soon as possible.*

Vacation Pay in Payroll Reports

Prior to July 1, 1971, the division's manual specifically excluded vacation pay from the payroll that was to be reported to the division. This regulation was based upon the provisions of Section 92-1121, R.C.M. 1947, which expressly excluded vacation pay. That is, wages paid to an employee while on vacation were to be deducted from the payroll reported. In 1971, Section 92-1121, R.C.M. 1947, was amended to require the inclusion of vacation pay. As a consequence, on July 1, 1971, the regulation was administratively changed to specifically include vacation pay in the payroll reported to the division.

A letter was sent by the state insurance program to all Plan III employers notifying them of several changes including the change on vacation pay. The only reference in the letter to vacation pay was a vague and unexplained statement as follows:

> "An Act to amend Section 92-1121 to delete the provision that salary and wages paid during actual vacation periods need not be computed or assessed became effective on its passage and approval on July 1, 1971."

The preceding statement does not say that vacation pay must now be included in the payroll reported to the state insurance program.

We contacted 12 employers to determine if vacation pay was being included in the payrolls reported to the state insurance program. Three employers were not including vacation pay and were not aware of the change in the division rules on vacation pay. The vacation pay excluded by these three employers amounted to $23,946. The exclusion of vacation pay in these instances resulted in an underpayment of premiums by $708. While this amount is not significant in itself, it represents uncollected premiums

from three employers out of a group of 12 employers which were randomly selected. As of January 1, 1974, there were approximately 11,000 employers in Plan III. Consequently, the possibility of more instances of unreported vacation pay is great and unreported vacation pay is a potentially significant problem.

RECOMMENDATION

We recommend that the division notify all employers in clear and concise language that vacation pay must be included in the payroll figures reported to the division.

Dividends

During fiscal year 1972-73, the state insurance program paid $18,393 in dividends to employers with premiums in default. As a consequence, employers not in default receive smaller dividends than they are entitled to receive.

Section 92-1110, R.C.M. 1947, states that in determining the amount of dividend, the division shall give consideration to the prior paid premiums and accident experience of each employer during the dividend year. Since dividends are a return of premiums, the premiums must be paid before they can be returned.

The division's manual states that employers may qualify for dividends if they are not in default of payment of premiums. The division's chief counsel defined default as failure to pay a premium by the 16th of the month following the end of the employer's reporting period.

The $18,393 was distributed to 97 defaulting employers who were in default during the period upon which the dividends are based. Of the total amount, $14,608 was applied against delinquent premiums by the state insurance program, and $4,785 was paid directly to the defaulting employers by state warrant. Dividends are applied to defaulting employers' accounts

through a manual process which compares the dividend register report to the premium due report and applies the dividends to these accounts. The underwriting supervisor stated that this occurs because the data processing procedures used do not differentiate between payroll and premium reports received and paid and payroll and premium reports received but not paid.

RECOMMENDATION

We recommend that the division:

1. *Establish data processing procedures to distinguish between payroll and premium reports which have been received but not paid and those which have been received and paid.*
2. *Establish procedures to preclude the payment of dividends to employers who are in default on premium payments.*

Bad Debt Write-Off Procedures

The term "bad debts" generally refers to amounts which are uncollectible for various reasons. In the case of the state insurance program, bad debts are insurance premiums which are payable to the state insurance program by employers but are uncollectible.

Inasmuch as the state insurance program now collects premiums from over 11,000 employers, there are instances where premiums are uncollectible. Consequently, the state insurance program has written off uncollectible premiums through accounting adjustments which, in effect, cancel the uncollectible amounts. Bad debts have been written off by the state insurance program at irregular intervals over the past five years as shown by the following schedule:

Fiscal Year	Premium Due	Bad Debts Written Off
1969	$ 48,217	$ -0-
1970	30,288	20,525
1971	43,241	20,185
1972	103,161	-0-
1973	56,463	47,570
Total	$281,370	$88,280

Although the state insurance program has authority to cancel insurance coverage, there is no express statutory authority to write off or cancel uncollectible premiums. The authority to take such action is delegated by law to the State Department of Administration. Section 82-110(c), R.C.M. 1947, stipulates that the department may establish procedures for canceling or writing off balances carried on the books of state agencies which are uncollectible.

It should be noted that effective July 1, 1974, there will be established a state debt collection service under the jurisdiction of the Department of Revenue pursuant to the provisions of Title 84, Chapter 71, R.C.M. 1947. After July 1, 1974, all uncollectible premiums should be certified to the Department of Revenue for collection. If the premiums still cannot be collected, then Section 84-7107, requires that they should then be written off pursuant to procedures established in accordance with Section 82-110.

Although the Department of Administration is empowered to cancel or write off uncollectible amounts, we were advised by an official of the department that no procedures have been established to receive uncollectible balances from state agencies, maintain an account of the balances, and cancel or write them off. We were advised that uncollectible balances have not been

regularly transmitted to the department by state agencies and the department is aware of only a few hundred dollars in amounts which are uncollectible. Consequently, other state agencies with uncollectible balances like the division are apparently either carrying the balances on their books or are canceling or writing off the balances on their own.

Since the Department of Administration has the statutory responsibility and authority to account for and cancel or write off uncollectible balances due state agencies, the department should establish formal procedures within the statewide accounting system to transfer uncollectible balances from state agencies, account for them, and cancel or write them off. Agencies such as the division should notify the department of balances considered to be uncollectible and periodically institute procedures to transfer these balances to the department for cancellation or write-off.

In addition to the fact that uncollectible premiums have been written off by the state insurance program without expressed authority, the state insurance program allows uncollectible premiums to accumulate for extended periods of time before write-off procedures are taken. Analysis of the uncollectible premium balance written off for fiscal year 1972-73 disclosed the following:

Year Uncollectible Premium Originated	Number of Employers	Uncollectible Amount
1968-69	1	$ 55
1969-70	19	8,404
1970-71	17	16,706
1971-72	11	22,405
Total	48	$47,570

Continual accounting for these uncollectible balances by the state insurance program results in an administrative expense which is probably negligible but unnecessary. Once these balances are recognized to be uncollectible, they should be transmitted to the Department of Administration for eventual write-off or cancellation.

RECOMMENDATION

We recommend that:

1. *The Department of Administration establish procedures to receive, account for, and write off balances declared to be uncollectible by state agencies.*
2. *Effective July 1, 1974, the division certify uncollectible balances to the Department of Revenue for collection.*
3. *The division transfer balances to the Department of Administration on a regular basis once those balances are recognized as uncollectible.*

Actuarial Review

Successful operation of an insurance operation such as the state workmen's compensation insurance program is dependent upon a number of interrelated factors including sound fiscal management and the sufficiency of premiums to cover losses, establish reserves, and pay administrative expenses. To a certain extent the adequacy of fiscal management and sufficiency of cash flow can be assessed by independent auditors. In an insurance operation, however, it is generally recognized that actuarial analysis of the state insurance program is necessary to successfully operate for an infinite period of time.

An actuarial analysis considers the adequacy of fiscal management but is particularly directed at the insurance operations such as establishment of rates and reserves, prediction of losses, and the effect of anticipated and potential but unanticipated events such as catastrophes.

We engaged an actuarial consultant to determine, among other things (1) what the actuarial requirements of the state insurance program are, and (2) whether there are any obvious indications that the state insurance program is presently solvent or insolvent from an insurance standpoint. The full text of the actuarial consultant's report is included as Exhibit H on page 152.

Basically, the actuarial consultant stated that the solvency or insolvency of the state insurance program could not be fully determined without a formal actuarial review. Since such a review and formal actuarial opinion has not been rendered within the last 10 years, the actuarial consultant was unable to comment on the overall solvency or insolvency of the state insurance program.

The actuarial consultant stated that an actuarial review of the state insurance fund should be performed annually to:

1. Provide a summary of the assets and liabilities of the fund.
2. Determine the current year's gain or loss.
3. Determine necessary reserves.
4. Provide an objective analysis of the financial condition of the fund.

No complete actuarial review encompasssing both rates and reserves has been performed of the state insurance program for at least 10 years. In November 1969, an out-of-state actuarial firm submitted a report on the "Analysis of Reserves for Losses as of June 30, 1969." This report did not

certify the adequacy of reserves with a formal opinion, but rather stated that the analysis of data provided by the Fund indicates that reserves are currently adequate to discharge the liabilities now on the books of the Fund. Still, the overall insurance soundness of the fund was not evaluated nor attested.

From January 1971, to the present, a different out-of-state actuarial firm has been retained by the state insurance program to review rates and reserves. Since this firm was retained, three years ago, no report had been issued on the adequacy of reserves and no overall assessment and certification as to the soundness of the fund has been made from an actuarial standpoint. We could not find any formal written agreement that required the actuary to evaluate or certify the soundness of the fund with a formal written opinion.

Other states with workmen's compensation insurance programs similar to Montana, such as Arizona, Colorado, and Oregon, obtain a full actuarial review and assessment annually. We are not sure that such a full scale review is warranted for the Montana insurance program each year. It may be adequate to engage an actuarial firm periodically, such as every two or three years, to fully evaluate the condition of the fund. In the interim, the same actuary could be consulted with respect to proposed changes in underwriting, claim reserve, and claims benefit policies.

Since the overall condition of the state insurance program has not been fully assessed for some time and actuarial requirements of the fund are uncertain, an actuarial firm should be engaged by the division to evaluate the overall condition of the fund and identify the future actuarial needs.

RECOMMENDATION

We recommend that the division:

1. *Engage an actuarial firm specializing in workmen's compensation insurance to evaluate the overall actuarial condition of the fund and determine the future actuarial needs of the fund.*

2. *Establish a formal written agreement when engaging an actuary.*

ADMINISTRATIVE ASSESSMENTS

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ADMINISTRATIVE ASSESSMENTS

The administrative operations of the division are financed from two sources: (1) the loss adjustment account, and (2) the administration account. The loss adjustment account is the source from which the administrative costs of Plan III are financed. Income to the loss adjustment account is derived from a direct assessment against the premiums paid by Plan III employers. The money in this account is used to pay the direct operating expenses of the state insurance program (Plan III) including the administrative costs of the underwriting and claims processes and personnel.

The administration account derives its operating capital from four sources which include assessments levied on self-insured employers (Plan I) and insurance companies (Plan II) as well as a portion of the premiums paid by Plan III subscribers and miscellaneous fees. The income from these sources defrays the costs of a multitude of general type services offered by the Workmen's Compensation Division which includes the division's policy formulation, accounting, purchasing, finance, personnel, Plan I and II claims supervision, audit, maintenance of employer and accident files, safety inspection and training, enforcement of safety regulations, inspection of boilers, and licensing boiler operators. Since these general type costs are being incurred for the benefit of all three plans and income comes from all three plans, the division attempts to allocate the costs to each of the three plans.

Some of the costs are allocated to the three plans each month based on the percent of claims processed for each plan in the previous month. Other costs are allocated on the number of safety inspections and a third category, the cost of boiler inspections, is not allocated at all because each employer is charged directly for each inspection.

ASSESSMENTS

Assessments levied by the division on subscribers of the three plans are ostensibly made to pay each plan's respective share of the administrative costs. For the most part, the manner of assessment is provided for as follows: Plan I - Section 92-902, R.C.M. 1947, provides that the division may levy an assessment in an amount not to exceed three-hundredths of one percent of the annual payroll of each employer, but that no assessment shall be in an amount less than $200. Plan II - Section 92-1005, R.C.M. 1947, specifies that the division shall assess each insurer not to exceed three and one-fourth percent of its gross annual direct premiums, less dividends collected in Montana. Plan III - Section 92-116.1, R.C.M. 1947, stipulates that the division shall levy against the industrial insurance account an assessment in an amount deemed reasonable and necessary to provide adequate administrative resources.

These laws provide an assessment limitation for Plans I and II. However, for Plan III there is no limitation. That is, Plan III bears the cost of those expenses which are not defrayed by the income derived from the statutory assessment of Plans I and II. In recent years, the assessment income from Plans I and II has not been adequate to defray the costs associated with those plans and, as a consequence, Plan III has borne the expense. Since Plans I and II share of the costs exceeds the revenue limited by law, the division has paid these costs from the state insurance program (Plan III) which does not have the assessment limitation.

The effect of these statutory limitations on Plans I and II and the corresponding overassessment of Plan III is illustrated by the following data relative to the last fiscal year:

	Fiscal Year 1972-73		
	Plan I	Plan II	Plan III
Beginning Fund Balance	$ (77,485)	$ 76,038	$ 27,206
Assessments	$ 60,456	$ 236,383	$590,000
Expenses	130,133	345,457	448,957
Over (Under) Assessment	$ (69,677)	$(109,074)	$141,043
Ending Fund Balance	$(147,162)	$ (33,036)	$168,249

Note: The deficit between the positive balances in Plan III and the negative balances in Plans I and II was borne by the administrative fund.

The preceding table shows that during fiscal year 1972-73, the money available and derived by assessments of Plans I and II was insufficient to defray the expenses associated with those plans. The deficit between expenses and assessments was borne primarily by Plan III, a condition which will continue until such time as the method of assessing Plans I and II is revised.

More equitable assessment of Plans I and II would result if the following formulas were used to determine the administrative costs associated with each respective employer or insurer:

Plan I:

$$\frac{\text{Total Plan I Administrative Costs}}{\text{Total Gross Annual Payroll - Plan I Employers}} \times \text{Gross Annual Payroll of Each Plan I Employer}$$

Plan II:

$$\frac{\text{Total Plan II Administrative Costs}}{\text{Total Gross Annual Premiums Less Dividends for Each Plan II Insurer}} \times \text{Net Annual Premiums of Each Plan II Insurer}$$

A formula approach such as the foregoing should be used by the division to compute administrative assessments. The statutory requirements that Plan I employers pay three-hundredths of one percent of the annual payroll and the requirement that Plan II insurers pay three and one-fourth percent of the

gross annual premiums should be amended to a general requirement that employers and insurers under each plan pay their share of the administrative costs on the basis of an equitable formula established and applied in accordance with the provisions of the Montana Administrative Code.

RECOMMENDATION

We recommend that the division seek legislation necessary to:

1. *Repeal the specific percentage requirements of Sections 92-902 and 1005, R.C.M. 1947.*
2. *Establish statutory authority to recover administrative costs from employers and insurers on the basis of an equitable formula devised and applied in accordance with the Montana Administrative Code.*

ALLOCATION OF SALARIES

As stated at the beginning of this section, the costs of safety inspections are allocated to the three plans because all three pay for and benefit from this service. On the other hand, costs incurred in the Loss Adjustment Account are not allocated because they are all incurred for the benefit of Plan III and paid by Plan III subscribers.

Safety Bureau

The Safety Bureau's Mines Unit has a staff of seven--one secretary and six inspectors--that inspect mines operated by Plans I, II, and III employers. The salary of one inspector is allocated to Plans I, II, and III, based on the number of mines inspected for each plan in the prior month. The salaries of three other inspectors are funded on an 80% federal and 20% state basis. Salaries for the remaining two inspectors and the secretary are allocated directly to the Plan III fund, which is reserved for the direct operating expenses of Plan III. The salaries of these three personnel for 1972-73

totaled $23,820. Based on the number of mines inspections for each plan in that year, Plan III was incorrectly allocated $14,080. Plan I was relieved of $6,670 and Plan II $7,410.

An accounting official advised this allocation policy was instituted because Plan II insurance companies have safety inspectors so the division thought it would be appropriate for the state insurance fund to pay some of the safety costs.

RECOMMENDATION

We recommend that the division allocate all salary costs of the mine unit on the basis of mine inspections.

Compliance Bureau

The salaries of three individuals are not being allocated to the section or sections in which they work. All three salaries involve the Compliance Section and two of the three involve the silicosis program.

Employee A: This employee's annual salary of $8,688 is allocated to the Compliance Section; however, the individual works in the executive section which is allocated to Plans I, II, and III. This does not affect the costing at the present time because the Compliance Section's salaries are being allocated to all three plans. However, in another section of the report we recommend that the Compliance Section's salaries be allocated to only Plans I and II.

Employee B: This employee's annual salary of $4,320 is allocated to the silicosis program but the individual works in the Compliance Section. The silicosis program is financed from the General Fund, so the state is paying for salaries chargeable to Plans I and II.

Employee C: This employee's annual salary of $8,688 is allocated fully to the Compliance Section, but the individual actually works in both the silicosis program and the Compliance Section. This salary should be allocated to the program receiving the benefit of the work performed.

RECOMMENDATION

We recommend that the division allocate the cost of employee salaries to the activities which benefit from the employee's services.

DISTRIBUTION OF SALARY COSTS

The division attempts to allocate administrative costs to Plans I, II, and III and the Boiler Inspection program. This is done to match costs with the source of revenue. Plan I revenue comes from the self-insurers via assessments of their gross annual payrolls; Plan II revenue comes from the private insurance companies via assessments of the net premiums; and Plan III revenue comes from the premiums paid by the employers who subscribe to Plan III. In the case of Plan III, however, the premiums are not assessed per se, rather, the division utilizes a percentage of employers' premiums as needed to defray administrative costs.

Compliance Bureau

The Compliance Bureau evaluates the compensation paid to injured workers in Plans I and II to assure the injured workers are receiving the payments to which they are entitled. This supervision necessitates the maintenance of records on employers in Plans I and II and accident files on each of the injured workers. The salaries of the 18 employees in the Compliance Bureau are charged to the Administration Account. Since the division attempts to match all administration costs with the respective source of revenue, the cost of these salaries

is allocated. The division allocates these costs to Plans I, II, and III, rather than limiting the allocations to Plans I and II, the two plans to which they apply.

The salary costs are allocated to the three plans each month based on the previous month's number of claims processed for each of the three plans. The effect of this basis for allocating is shown below for a typical two-week pay period.

	Two-Week Payroll Period Ending 9/28/73		
	Allocated Costs For the Period	Allocation Based On Plans I & II Claims	Amount (Understated) Overstated
Plan I	$ 805.65	$1,153.86	$ (348.21)
Plan II	2,322.94	3,321.95	(999.01)
Plan III	1,347.22	-0-	1,347.22

We were advised by the fiscal supervisor that the above payroll period was not unusual but rather was representative of the 26 payroll periods in the year. Upon being advised of this situation during the course of our examination, division accounting personnel stated that corrective action would be taken.

RECOMMENDATION

We recommend that the division allocate the costs of the Compliance Bureau to only Plans I and II.

Safety Bureau

The Safety Bureau is responsible for inspecting mining and industrial operations, safety training, and enforcing safety regulations. The costs incurred in these functions are administrative costs and are allocated to the three plans to match the costs to the revenues. The bureau also inspects

boilers and licenses boiler operators. This cost is not allocated to the three plans because it has a different source of revenue, statutory fees rather than assessments of Plans I, II, and III. Consequently, there are four general sources of revenue to pay the costs of the Safety Bureau, i.e., assessments of Plans I, II, and III, and fees from boiler operations. However, the basis for allocating costs to Plans I, II, and III is the number of safety inspections performed on Plan I, II, and III companies, plus the number of boiler inspections.

The effect of this basis for allocating to the three plans is shown below:

	Two-Week Payroll Period Ending 9/28/73		
	Allocated Costs For the Period	Allocation Based On Safety Inspections Only	Amount (Understated) Overstated
Plan I	$ 485.56	$ 528.37	$(42.81)
Plan II	1,854.28	1,694.09	160.19
Plan III	1,483.42	1,600.80	(117.38)

We were advised by the Safety Bureau that the payroll period reviewed was not unusual but rather was representative of the 26 payroll periods in the year.

This method of allocation does not consider that the inspection time spent on one firm often varies significantly from the inspection time spent on another firm. Plan I firms, being very large, take a greater amount of time to inspect than the smaller firms that subscribe to Plans II and III. At the present time, each inspection is given equal weight. This becomes important in light of the following: Two division officials advised us that the objective of distributing costs to Plans I, II, and III is to match costs with the related assessments and fees as a basis for requesting periodic assessment and fee rate increases. If the proper costs are not matched with

the proper revenues, some employers will be paying some costs that should properly be borne by those in another plan or plans.

Records of time spent on each inspection are kept by all inspectors in the Safety Bureau except mine and boiler inspectors. About 65 percent of the direct labor is already being recorded in a manner that allows direct labor costing. The Safety Bureau's administrative time is directly related to the field inspector's time. From these records we were able to compare the actual allocated costs to the costs that would have been allocated based on direct labor. We used the payroll period ending September 28, 1973, which the division agreed was a representative period. The results of this comparison are in the schedule below:

	Plans			
	I	II	III	Total
% of Inspections Made	3%	47%	50%	100%
% of Direct Labor	5%	51%	44%	100%
Difference	(2%)	(4%)	6%	
Costs Allocated on Inspections	$116	$1,570	$1,657	$3,343
Costs Allocated on Direct Labor	152	1,710	1,481	3,343
Difference	($ 36)	($ 140)	$ 176	

RECOMMENDATION

We recommend that the division use direct labor hours of safety inspectors as a basis for allocating the cost of the Safety Bureau to Plans I, II, and III.

REPORTING AND PROCESSING OF INDUSTRIAL INJURIES

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REPORTING AND PROCESSING OF INDUSTRIAL INJURIES

Industrial injuries within the context of workmen's compensation laws are defined by Section 92-418, R.C.M. 1947, as follows:

> "Injury or injured means a tangible happening of a traumatic nature from an unexpected cause or unusual strain, resulting in either external or internal physical harm . . . "

Although the foregoing pertains specifically to a traumatic event, 1973 amendments to the law also allow recognition of injuries in the area of cardiovascular, pulmonary, and respiratory disease. As a consequence, the definition of an industrial injury is broad.

Almost the entire existence of the division and the workmen's compensation laws it administers is based upon the premise that industrial injuries will occur. To this end, the collection and processing of industrial injury reports is a major activity within the division.

Prompt and accurate injury reports are singularly important in the timely delivery of benefits to injured workmen, and are also important from the standpoint of rate-making and statistical report preparation. Consequently, the requirements underlying industrial injury reports are delineated by law and regulation. These requirements generally pertain to all three plans administered by the division. The occurence of industrial injuries must be reported to the division irrespective of whether the employers are self-insured (Plan I), commercially insured (Plan II), or insured through the state insurance program (Plan III).

Section 92-807, R.C.M. 1947, specifies that employers must be notified of industrial injuries by injured employees within 60 days unless the employer already has knowledge of the injury. Upon receiving notice of an injury, employers are required by the division to submit a report to the division within six days.

Reports of industrial injuries emanate from three general sources, depending upon the plan involved. In the case of the State insurance program (Plan III), injury reports are received directly by the division from employees, employers, and attending physicians. In the case of self-insurers (Plan I), the employee, employer, and attending physician reports are usually transmitted to the division by the employer, although reports are also received from employees and attending physicians. Under Plan II (commercial insurance companies), the employee, employer, and attending physician reports are sent to the division by the insurance company as well as employees, employers, and physicians.

Irrespective of the source of the reports, three basic reports are required by the division for all industrial injuries. These reports are as follows:

1. Employee's report: Form number 54, titled Claim For Compensation.
2. Employer's report: Form number 37, titled Employer's First Report Of Occupational Injury or Disease.
3. Physician's report: Form number 39, titled Attending Physician's First Report and Bill For Initial Treatment.

The mere fact that an industrial injury is reported does not necessarily mean that a claim for workmen's compensation benefits will materialize. In fact, numerous industrial injuries are reported which never materialize into claims for benefits, as illustrated by the following table:

WORKMEN'S COMPENSATION DIVISION

INJURIES REPORTED COMPARED TO CLAIMS FILED

Fiscal Year	Plan I	Plan II	Plan III	Total	Percent Claims To Injuries
1969-70					
Injuries	3,107	10,151	9,218	22,476	
Claims	660	1,663	1,732	4,055	18.0%
1970-71					
Injuries	3,034	9,724	9,228	21,986	
Claims	639	1,179	1,669	3,487	15.9%
1971-72					
Injuries	2,822	9,995	9,622	22,439	
Claims	585	1,435	1,678	3,698	16.5%
1972-73					
Injuries	3,216	11,366	9,239	23,821	
Claims	729	1,825	1,578	4,132	17.3%

Source: Workmen's Compensation Division documents, Work Injuries in Montana.

The wide variance between injuries reported and claims filed stems from the fact that the law requires that all injuries be reported, no matter how trivial or insignificant. A requirement such as this is essential from the standpoint that it establishes the fact that an accident occurred and an employee was injured.

Aside from the fact that a claim for compensation benefits may later materialize as a result of accidents, information on the occurrence of injurious accidents is important from a statistical standpoint in the private sector and nearly all levels of government. The information compiled by the division is the sole source of comprehensive statistics on the type of industrial injuries, rate of occurrence, and occupations involved.

Consequently, timely, comprehensive, and accurate reporting of injuries is basic to effective operation of the workmen's compensation program.

INDUSTRIAL INJURY REPORTS

Section 92-807, R.C.M. 1947, requires that employees notify their employers of industrial injuries within 60 days, while Section 92-808, R.C.M. 1947, stipulates that employers and insurance companies must submit reports of injury to the division within the time frame prescribed by the division. The division has required, through the Montana Administrative Code [24-3.18(10)-S1830] that form number 37, the Employer's First Report of Injury, be filed with the division within six days. The division has established a requirement [Mac 24-3.18(10)-S1840] that the attending physician's initial report of injury (form 39-1) must be filed with the division within 48 hours of the time the medical treatment is rendered.

The importance of the requirement for injury reports is further underscored by the fact that Section 41-1718, R.C.M. 1947, a provision of the state industrial safety laws, provides that any employer who fails to report an injury as required by Section 92-808, R.C.M. 1947, is guilty and subject to the penalties of a misdemeanor, in addition to a civil penalty of not more than $1,000. These penalty provisions, as well as the statutory and regulatory requirements pertaining to the filing of injury reports, make it apparent that injury reports are an important aspect of the workmen's compensation laws.

Irrespective of the statutory and regulatory requirements, we found several instances where injuries were not reported and several indications that a significant number of industrial injuries may never be reported to the division. In addition to the fact that all injuries are not being reported, the division has not established any effective means of assuring that injuries

are reported as required by law and, as a consequence, does not know if all injuries are being reported.

The fact that all injuries are not being reported is difficult to illustrate since it refers to the absence of a report which should have been filed but was not. Various personnel within the division advised us they are confident all injuries are not being reported. These personnel stated that in various instances, the medical costs associated with injuries are paid by the employee, the employer, or a private insurance carrier without any injury report being filed with the division. We observed several instances where the division received medical bills for services rendered by a physician, hospital, pharmacy, etc., which cannot be correlated to injury reports. In these instances, the division requests the employer and employee to submit the appropriate injury reports. Frequently the employer responds by advising the division that the medical bills were already paid by the employer. In these instances, and particularly under Plan III, the matter is dropped by the division and no further action is taken to obtain an injury report.

We followed up on 47 instances where medical reports or medical bills had been filed with the division, without a corresponding employer's report of accident. We contacted the 47 employers and found several different situations. None of the accidents had been reported to the division. Seventeen employers confirmed that they did not have workmen's compensation insurance; 29 employers had paid the medical bills for their employees; two private insurance carriers had paid the medical bills; and three employees ended up paying their own medical bills because their employers did not have coverage.

In another instance, we noted where a construction company has a policy of directly paying all medical bills under $25 and not reporting the injuries to the division. Since these injuries are not being reported to the division, the records do not show how many there have been. Division personnel were aware of this company's practice but injury reports required by law are not being obtained.

Ordinarily the omission of reports on trivial or slight injuries would seem insignificant. In the case of workmen's compensation, however, the absence of injury reports has several ramifications. First, the trivial or slight injury could materialize into a serious injury. Under existing law, the failure of the employee and employer to report the injury within the required time frame could deprive the employee of his right to workmen's compensation benefits.

Secondly, failure to file injury reports results in a direct understatement of injury statistics compiled by the division for analysis, publication, and dissemination to federal, state, and private organizations. Thirdly, the absence of injury reports precludes analysis to determine whether safety or employment of minors violations exist, and finally, the failure to file injury reports is a direct contravention of the requirements of law, which is subject to mandatory criminal and civil penalties.

Inasmuch as injury reports are the cornerstone of the workmen's compensation program, specific measures should be taken by the division to: (1) identify and assure that all injuries are reported; (2) follow up on all instances where unreported injuries are identified; and (3) initiate the appropriate legal action provided for by law. In this connection, the Federal Occupational Safety and Health Act (OSHA) required employers to keep basic records on industrial injuries. When the division conducts field audits, these basic records should be reviewed to identify unreported injuries.

RECOMMENDATION

We recommend that the division:

1. *Establish field examination and other procedures to insure that all injuries are reported as required by Sections 92-807 and 808, R.C.M. 1947.*
2. *Institute routine follow-up procedures for use in those instances where unreported injuries are identified.*
3. *Initiate legal action in those instances where injuries have not been reported and such action is appropriate.*

EMPLOYER REPORTS

As previously mentioned, Section 92-808, R.C.M. 1947, gives the division authority to prescribe time limits on reporting deadlines. As a result, the division has established provisions in the Montana Administrative Code requiring employers to submit the Employer's First Report of Injury (form 37) within six days of notice of an industrial injury. The six-day requirement prescribed in the Montana Administrative Code became effective and binding upon employers on January 1, 1973. This time frame may have been based upon the fact that injured employees become eligible for compensation benefits after seven days of lost work time. Accordingly, the division wants reports on injuries before that happens, hence the six-day requirement. Prior to that time, the published rules of the division required employers to submit their report "without delay."

We found that few employers submit injury reports within the time frame set by law and regulation. As a matter of fact, most employer reports were significantly delinquent, as illustrated by the following table.

Number of Employer Injury Reports		Time From Notice of Injury to Submission of Reports
Plan II	Plan III	
7	9	6 days
3	0	6 to 10
8	6	10 to 20
4	5	20 to 30
2	1	30 to 50
1	1	50 and over

Average time: Plan II 17 days

Plan III 18.4 days

As shown above, only seven employers under Plan II and nine employers under Plan III submitted their injury reports within the time frame prescribed by law and regulation. These employers in compliance with the requirement constitute only 28 and 41 percent, respectively, of the employer injury reports tested. Consequently, it is obvious that many employers are not complying with the requirement that injury reports be submitted within six days. None of the compensation benefits were paid on these claims until the employer's injury reports were received. As a consequence, the delivery of benefits to the injured employee was significantly delayed.

As previously mentioned, Section 41-1718, R.C.M. 1947, specifically states that failure to file injury reports as required by the division constitutes a misdemeanor and is cause for criminal and civil penalties. In addition, the Montana Administrative Code, MAC [24-3.18(10)-S1830], stipulates that a failure of the employer to file an injury report within six days, which results in a delay of benefit payments, empowers the division to:

1. Require employers operating under Plan I and II to pay a deposit for 12 months in advance, and

2. In the case of Plan III employers, pay a penalty of five (5) percent of the annual premium.

While both the statutes and Montana Administrative Code prescribe penalties for non-compliance, the legal counsel for the division expressed the belief that the division has no authority to adopt penalties through administrative rules. Consequently, the legal counsel questioned the validity of the penalty provisions of the Montana Administrative Code, but not the law.

Although division personnel were aware of the general delay in employer injury reports, little, if anything, has been done to correct the situation. The mandatory penalties provided by law have rarely been assessed, and no methodical means has been considered to detect non-compliance and induce compliance. One division official responsible for overseeing employer injury reports advised us that he was not aware of the penalty provisions of the Montana Administrative Code until we brought them to his attention. Other division officials, apparently aware of the penalty provisions, stated that they have attempted to maintain a good relationship with employers and induce compliance through education rather than enforcement. As a consequence, the division has not consistently sought the penalties required by law and regulation.

Inasmuch as the division has not made a concerted effort to detect violations and induce compliance, it is possible that many employers are unaware of the reporting requirements. No broad scale effort has been made by the division to inform all employers of the fact that employer reports of injury are required within six days of employee notice of accidents. This should be done by the division directly with all employers as a preliminary step toward inducing compliance. In addition, the division should (1) establish a requirement that employers and insurance companies date stamp injury reports

upon receipt to provide the division with a basis for analyzing injury reports for compliance, (2) establish field examination procedures to evaluate compliance, such as review of the basic OSHA records, and (3) when appropriate, seek enforcement of penalties provided by law and by regulation.

RECOMMENDATION

We recommend that the division:

1. *Advise all employers of the mandatory reporting requirements and penalties prescribed by Sections 92-808 and 41-1718, R.C.M. 1947, and the Montana Administrative Code.*
2. *Require all employers and insurers to date stamp all injury reports upon receipt from employees, employers, and physicians.*

PHYSICIAN REPORTS

As is the case with employee and employer reports of injury, reports are also required from attending physicians. The Montana Administrative Code, MAC [24-3.18(10)-S1840] specifies that:

> "The attending physician shall within 48 hours submit, Attending Physician's Initial Report, (Form 39-1 hereafter) to the insurer or the Division."

This requirement is not stated in law, nor is there specific statutory authority for adopting such a regulation. However, Section 92-814, R.C.M 1947, authorizes the division to do and perform any and all things which are necessary or convenient in the administration of the workmen's compensation laws. As a consequence, the authority of the division to set a 48-hour time frame is presumed.

Our review disclosed that attending physicians rarely submit their reports within the 48-hour time limit required by the division. Our test

of physician reports did not disclose a single instance where a physician submitted his report within the 48-hour time frame. The results of our test are depicted below:

PLAN II		PLAN III	
Number of Physicians' Reports	Average Time From Treatment to Submission of Report	Number of Physicians' Reports	Average Time From Treatment to Submission of Report
None	48 hours	None	48 hours
1	5 days	6	6 days
5	12 days	7	10 days
6	22 days	13	20 days
6	52 days	5	72 days
Average overall time from treatment to submission of report - 29 days.		Average overall time from treatment to submission of report - 24 days.	

The promptness of attending physician reports for injuries could not be determined for Plan I employers because the sample cases selected for review did not have date stamps. Consequently, the records did not show the date on which attending physician reports were received.

As was the case with employer injury reports, delayed physician reports also contributed to a substantial delay of compensation benefits. In 28 of 35 cases where compensation benefits were paid in our sample, the compensation benefits were delayed because the physician reports were not received on a timely basis. This is because the division considers the physician report an instrumental document in establishing the propriety of an injury claim. The physician report is supposed to provide independent verification that an injury occurred, as well as expert evidence as to the nature and extent of the injury. In an effort to obtain more timely physician's reports in individual cases, the division has adopted time-consuming procedures such as follow-up letters and telephone calls to physicians, all

of which result in additional expense and do not solve the basic problems.

Division officials believe the 48-hour requirement is reasonable from the standpoint that the circumstances and results of the treatment are fresh in the physician's mind, thereby resulting in a more usable report. To this end, they have conducted training of physicians' staff on an irregular and unscheduled basis and have made presentations at the annual meetings of the Montana Medical Association. Nevertheless, this has not solved the problem according to division officials who express the belief that the establishment of penalties would have an adverse effect in that physicians will not treat workmen's compensation cases.

At this point, the reasons for such extensive delays and the possible effect of penalties and enforcement are conjecture. The division does not have a systematic means of identifying physicians who are delinquent in filing reports and does not know precisely why physicians' reports are delinquent.

The division should undertake a study to determine the reasons why physicians' reports are so delinquent and what alternatives are available. This study should include consultation with individual practitioners as well as the State Board of Medical Doctors, the Montana Medical Association and its affiliate, the Montana Foundation for Medical Care. An approach such as this would identify possible solutions. For example, the Department of Social and Rehabilitation Services and Montana Foundation for Medical Care have devised a procedure whereby the hospitalization of Medicaid recipients is promptly identified. This procedure, utilizing a form entitled "Metric Certification," enables the Foundation on behalf of the Department to identify and monitor hospitalization and treatment of Medicaid recipients. The same or a similar procedure could be used by the division to insure that injured workmen entitled to compensation benefits are promptly identified.

In addition, the division could consider an incentive to induce timely physician reports. Section 92-1119, R.C.M. 1947, specifies that under Plan III, physicians can be paid $1.50 for providing reports to the division in compliance with law. This $1.50 is in addition to the customary fee charged by the physician for the services rendered, which itself is compensable under the workmen's compensation insurance laws. Although this additional compensation of $1.50 is relatively insignificant and limited to Plan III, the division could consider seeking the statutory authority necessary to expand the concept to all plans. That is, establish an incentive fee for those physicians who submit reports within the time frame desired by the division.

As a last resort, the division should consider punitive action in the case of those physicians who are consistently negligent and delinquent in the filing of physician reports.

RECOMMENDATION

We recommend that the division undertake a comprehensive study to determine the reasons why physician reports are excessively delinquent and the alternatives available to remedy the problem.

PROCESSING SYSTEM

As previously discussed the division is the sole state agency responsible for both the administration of the state workmen's compensation laws and the state industrial insurance program. In conjunction with these responsibilities, the division receives and processes voluminous documents of different types from enumerable sources such as employees, employers, physicians, insurance companies, and many state and federal agencies. The heart of the system, however, consists of injury reports and related documents all of which must be processed in a prompt and efficient manner.

Prompt and efficient processing of injury reports is essential so that injured employees can be identified as soon as possible and appropriate medical and disability compensation benefits can be delivered without delay. In preceding sections of the report we have presented information on problems which affect the delivery of workmen's compensation benefits. These problems include matters such as absence of employer coverage, failure of employers to report accidents, and substantial delays in the receipt of employer and physician reports relative to industrial injuries. These problems all contribute to delay and inefficiency in the delivery of workmen's compensation benefits. Another facet to the problem of delay and inefficiency, is the manner in which industrial injury reports and claims for benefits materialize and are processed.

Our review of the processing system disclosed areas where improvements could be made to promote efficiency, reduce delay, and improve the overall operations of the division. The need for these improvements is fairly evident now with the division responsible for administering workmen's compensation laws governing approximately 17,000 employers, of which approximately 11,000 are directly insured under the state industrial insurance program. The need for these improvements will become critical when the division completes enrollment of agricultural employers as required by the 1973 amendments to the Workmen's Compensation Act. It is expected that the enrollment of agricultural employers will double the number of employers previously covered by workmen's compensation insurance thereby making the present problems more acute. Consequently, the following improvements are warranted.

Injury Reports

Under present procedures, at least, three documents are received by the division in conjunction with each industrial injury claim. Under all

three plans separate reports pertaining to the injury are received from employees, employers, and attending physicians. Each of these reports are important from their own standpoint, and expeditious processing of them is necessary for prompt delivery of benefits. The employee's report (Claim for Compensation, form 54) establishes the fact that an injury is alleged to have occurred under work-related circumstances and that the employee is ostensibly eligible for workmen's compensation benefits. The employer's report (Employer's First Report of Occupational Injury or Disease, form 37) corroborates the employee's claim and provides the basis for a payment of the benefits, if appropriate. The attending physician's report (Attending Physician's First Report and Bill for Initial Treatment, form 39) delineates the nature and extent of the injury and provides an independent verification that an injury did occur.

New files are created for each injury report that is sent to the division. The information on these reports and other claim information is entered in the data processing system, processed through various stages of review and handling, and eventually filed in folders which are placed on storage shelves within the division. Currently, the storage shelves are jammed with claim files, and even though the department is using a microfilm process, the claim files are proliferating and will continue to do so, particularly with the completion of enrollment and influx of injury reports and claims from the agricultural sector. The following table depicts the number of injuries and claims in recent years.

Fiscal Year	All Plans	
	Number of Injuries	Number of Claims
1972-73	23,821	4,132
1971-72	22,439	3,698
1970-71	21,986	3,487
1969-70	22,476	4,055

Source: WCD report - Work Injuries in Montana and Plan III Pay Lag Data.

Inasmuch as it appears that the volume of documents received, handled, processed, and stored by the division will increase, any means of reducing the number of documents associated with each claim would be beneficial. The processing system could be improved and a significant reduction in the volume of documents attained and the delivery of benefits enhanced through consolidation of documents wherever possible.

Presently, employee verification of the injury is provided by means of the "Claim for Compensation," form 54. This form is sent to injured employees by the division in those instances where the division has received evidence from other sources that an injury occurred. The division sends this form to the employee to insure that if he has or will have a claim for benefits, the right to that claim is established. Many of the injuries reported to the division do not materialize into claims. Nevertheless, the division wants the employee's verification that the injury occurred; consequently, a claim form is sent.

A better way to obtain employee verification of the injury would be to modify the Employer's First Report of Occupational Injury or Disease (form 37) to provide space for the injured employee to (1) certify or acknowledge that an injury occurred under the circumstances and conditions described by the employer, and (2) indicate that a claim for compensation

(a) will be filed, (b) will not be filed, or (c) is undetermined. Modification of the document in this manner would provide immediate benefits as follows: It would:

1. Document the occurrence of a work-related injury.
2. Provide a positive record of the employee's right to later file a claim within the time stipulated by law.
3. Provide the division with a positive means of ancitipating the extent to which injuries might become claims, thereby facilitating decisions as to the adequacy of reserves.
4. Eliminate the need for separate employer and employee reports, thereby reducing the volume of claim documents presently received.
5. Accelerate the processing of injury reports which were previously held up due to delinquent employee or employer injury reports.

Although consolidation of the employer and employee reports would present the possibility that employers would not forward the combined reports to the division, this would be no different from the present situation where most employee reports are transmitted to the division by employers on behalf of their employees.

RECOMMENDATION

We recommend that the division modify the Employer's First Report of Occupational Injury or Disease (form 37) to provide for:

(a) Employee acknowledgement of the injury.

(b) Declaration of employee intent/deliberation to file a claim for compensation.

Employer Numbers

The ability of the division to quickly determine whether an injured workman's employer has workmen's compensation insurance is one of the key factors in processing documents, assigning accident numbers, establishing claim files, and eventually paying compensation benefits. Presently the division manually screens the documents through an employer card file to determine whether the employer is covered under Plan I, II, or III. The card files list the employers alphabetically by name. Incorrect or incomplete employer business names or changes in the business name make it difficult for division employees to verify coverage which, in turn, delays the entire processing function as well as compensation payments.

For example, the employer's name on an attending physician's report received by the division was incomplete but it was similar to another business name in Plan III employer card files. The file clerk changed the employer's name on the physician's report to conform to the name on the Plan III file. It was approximately 90 days before it was accidentally discovered that the appropriate employer was actually covered under Plan II.

In another case, the division received a physician's report on September 20, 1973, showing a certain employer's name, Company "A." The Plan III employer card file included a card for a company with a similar name located in Fargo, North Dakota. The division requested an employer's report from that company and received a response stating that they had not performed any work in Montana during the particular year and did not have an employee by the name of the injured claimant. The company from North Dakota also suggested that the employer could be a Washington-based firm with the same name. The division did not attempt any further followup except to notify the physician that they had no record of the employer.

Our review of reference information disclosed that the appropriate company was actually located in Butte, the place where the accident was supposed to have occurred. The firm changed its name and was based in Washington with a branch office in Butte. We telephoned the Butte office and they confirmed that the injured employee was working for them when the accident occurred. Nevertheless, the claim file was held in suspense and the physician's bill had not been paid as of January 21, 1974, which is about four months after the physician's report was received.

Insurance companies, whether they are medical, homeowners, automobile, etc., emphasize the use of the policy numbers for the purpose of identifying coverage. Generally, claims, correspondence, etc., sent to the insurance companies include a reference to the policy number. The insurance companies encourage and, in some cases, insist that the number be shown on all documents. The utilization of a number by the division for each employer would preclude the problems encountered from incorrect spelling, incomplete titles, or changes in the employer's business name and style. Presently, the division assigns each employer a number but does not use this number in the processing of claims and related documents.

Inasmuch as there are presently several systems used to identify employers and employees and the records related to each, the division should review the various systems presently in use and seek a more effective method of identifying and filing employer and employee-related records. One manner in which this could be accomplished would be through greater use of employer numbers as policy numbers.

RECOMMENDATION

We recommend that the division review the present procedures used to identify and file employer and employee-related records.

Employer Number Cards

The division presently relies on injured employees to orally furnish accurate information to physicians, druggists, hospitals, attorneys, etc. As a result of their services to injured employees, these various parties as well as others communicate with the division and the insurers through documents such as bills, correspondence, etc. The identifying information on these documents is frequently vague, incorrect, and incomplete and, as a consequence, it is difficult and at times, impossible to correlate the documents to the appropriate employer, employee, or claim file.

In the case of Plans I and II, the employers and insurers are responsible for processing the documents they receive. They are responsible for payment of bills, requesting additional reports, resolving conflicts, etc., and therefore the employers and insurers normally receive documents directly from the providers of services. On many occasions, however, the documents are sent directly to the division rather than the employer or insurer.

The documents are apparently sent to the division in error because the interested parties are unaware of the involvement or correct address of the insurer. The injured employee and the interested parties are no doubt aware that the case pertains to an industrial accident and therefore send the information to the division.

It is common practice in the insurance industry for insurance companies to provide policyholders with an identification card reflecting essential information such as policy number and the company name and address for claim purposes. These cards are commonly used for presentation to physicians, hospitals, druggists, etc., for the purpose of providing accurate insurance information. Such cards do not obligate the insurance company but merely serve to provide the information necessary to expedite and process billings.

The adoption of an employee card system by the division for all injured employees would decrease the number of documents unnecessarily received by the division, which subsequently require forwarding to employers and insurers.

The division should establish such an identification system. All employers should be provided standard cards prepared by the division which depict the employer's number and name, the name of the insurer, and the address for the mailing of claims and documents. Inclusion of the employer's number on the card would serve to expedite processing of documents because the parties submitting documents will be obtaining accurate information from a written form rather than verbally from the injured employee.

Employers should be instructed to give these cards to employees who have incurred industrial injuries, and employees should be instructed to use these cards when requesting assistance or services from vendors, insurers, or the division in conjunction with their workmen's compensation insurance coverage.

RECOMMENDATION

We recommend that the division:

1. *Provide all employers with standard identification cards for distribution to employees who have been injured and are entitled to coverage under the various workmen's compensation insurance plans.*
2. *Request employers to instruct injured employees to use these cards when seeking assistance or services under the workmen's compensation insurance program.*

Internal Processing System

In addition to the recommendations discussed in the preceding sections of this report, the internal processing system of the division should be changed to improve its overall efficiency and effectiveness. One universal criticism of agencies administering workmen's compensation programs concerns the delays in the first payment of compensation to the disabled worker. Full and prompt payment is essential because few workers can afford to wait long for benefits due. One of the objectives of the division is to preclude the time gap between the date of injury and the receipt of the compensation payments by the claimant.

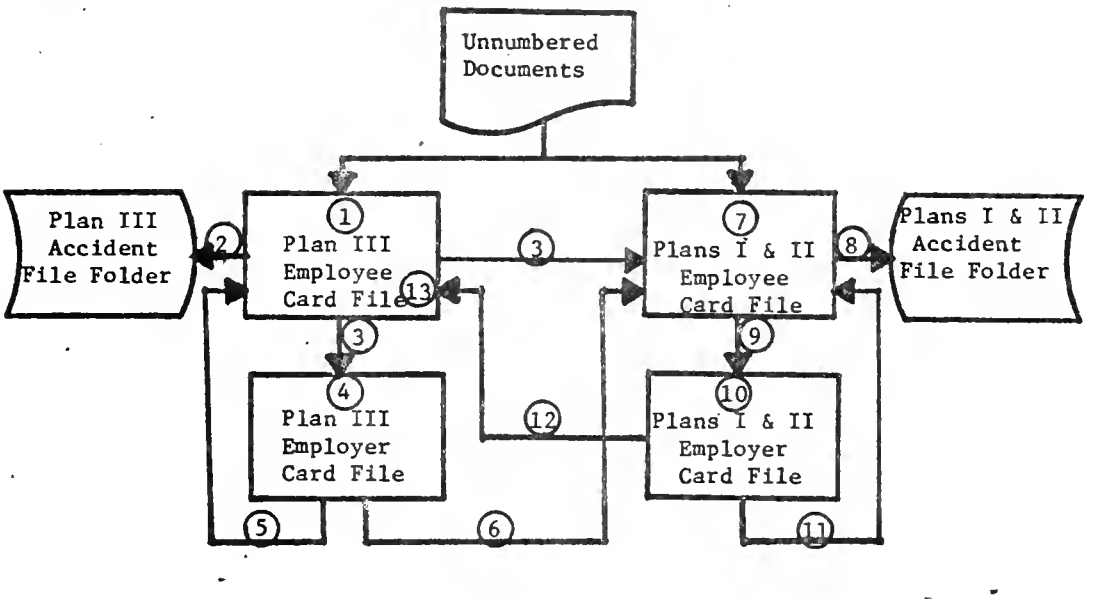
The achievement of this objective depends to a great extent on the procedures and methods followed in the processing system and on the abilities, knowledge, and training of the employees responsible for implementing the system.

Several improvements can be made in the following areas:

Processing Procedures

The major purpose of the processing system is to review all incoming documents, identify them to a particular industrial accident, assign an accident number, and include the documents in an accident file. Documents received by the division are either numbered or unnumbered, depending on whether or not the sender writes the accident number on a document. Accident numbers assigned by the division distinguish between the year the accident occurred and the plan under which the employer is covered. For example, 59B-6618 refers to 1973-74 (59th year of operation) and Plan II. Numbered documents are sent directly to the file clerks and inserted in the accident files.

The processing system of the division is divided into two separate sections, i.e., Plans I and II, and Plan III. All documents received which are identifiable with Plan I and II are sent to the personnel responsible for those plans. Most unnumbered documents are sent to the Plan III section. The manner in which unnumbered documents are processed is illustrated by the following diagram and related comments which illustrate the complexity and confusion of the process:



1. Employee alphabetizes all unnumbered documents by claimant and searches in the employee card file to determine if accident has been previously identified and assigned an accident number.

2. The accident number is written on all documents identified and the documents are sent to be included in accident file folders.

3. Employee, shown in step 1, reviews the remaining unnumbered documents and sends then to Plan III or Plans I and II, depending on what plan she believes the employer is covered under based on her experience and knowledge. This employee was employed about six months ago.

4. Employee alphabetizes documents by employer name and searches in three different locations within Plan III card file to determine if the employer has coverage.

5. Documents for which coverage is verified under Plan III are returned to employee card file, a search is again made to determine if accident was previously assigned a number; if it is a new accident and the particular document is an employer's or employee's report, an accident number is assigned, a card included in the file, and an accident file prepared. In the case of all other documents, including physician's first report of injury, the other major reports (employer's, employee's, or physician's) are requested and the document received is placed in a suspense file awaiting return of the documents requested.

6. Documents for which there is no Plan III coverage are sent to Plans I and II.

7. Employee in Plans I and II alphabetizes documents by employee and performs the same search as discussed in "1" above.

8. The accident number is written on all documents identified and the documents are sent to be included in accident file folders.

9. Remaining unnumbered documents are sent to employer's card file.

10. Employee alphabetizes documents by employer and performs the same steps as shown in "4" above.

11. Documents for which coverage is verified under Plan III are returned to employee card file, a search is again made to determine if accident was previously assigned a number; if it is a new accident and the particular document is an employer's or employee's report, an accident number is assigned, a card included in the file, and an accident file prepared. In the case of all other documents, including physician's first report of injury, the other major reports (employer's, employee's, or physician's) are requested and the document received is placed in a suspense file awaiting return of the documents requested.

12. If no coverage, the documents are returned to Plan III.

13. At this point, the documents may be rechecked through the same maze and if, at some point in time, there is a determination that there is no coverage under any of the plans, the sender of the document is notified of this fact.

The complexity of the diagram and description of the process typifies the confusion and problems of the system. The major problems with the present procedures and methods fall into two main areas, both of which increase the processing time, delay the establishment of accident files, and delay the payment of compensation or medical bills. The first major problem area is that all incoming documents are segregated between the plans, based on the experience of the employee, without any written guidelines or procedures. This segregation occurs at two places within the system. The mail room clerk and the Plan III accident file clerk segregate and send documents directly to the personnel responsible for Plans I and II. An employee, responsible for processing Plan I and II documents, estimated that out of the approximate 600 documents received each day, she must forward over 100 to Plan III because the employer is not covered under Plans I and II. This means that over 26,000 documents a year are screened through the Plans I and II employee accident file and employer card file without any chance of the accident being related to Plans I and II.

The second major problem area is that the first step in the process under all plans is to search an employee accident card file to determine whether an accident number has been assigned. This step is accomplished before it is determined the plan under which the employer is covered. Since the majority of the documents are first sent to the Plan III section, the division unnecessarily screens many documents through a Plan III file (employee accident card file) which should have been sent directly to Plans I or II. For example, based on the number of Plan I and II injuries (14,582) during 1972-73, and estimating a conservative minumum of three documents per injury, as many as 43,746 documents were screened through the Plan III file, where there was no chance of making an identification because the employer's were covered under Plans I or II.

The foregoing problems would be overcome to a large extent if the division modified its procedures to provide that the first step in processing documents be determination as to which plan (Plan I, Plan II, or Plan III) the document pertains. This would avoid Plan III personnel screening documents which pertain to Plans I or II and vice versa. It would also eliminate repetitious screening and would serve to expedite the processing of these documents.

The division has not reviewed the processing system in total to identify the problems and make the necessary corrections. The system is separated into two sections and no one individual is responsible for coordinating and supervising the entire system.

We have been advised that the National Council on Compensation Insurance, of which the division is a member, offers assistance to its members in the area of organizing and reorganizing file and document processing systems. Such assistance has been provided other states such as Arizona when major changes in the workmen's compensation programs were undertaken. Inasmuch as the national council receives data from all states and insurers and is somewhat familiar with the procedures used in other states, the national council is in a key position to provide assistance to its members. For this reason, the division should consult with the national council as a preliminary step in improving the manner in which workmen's compensation data and documents are processed and filed.

RECOMMENDATION

We recommend that the division:

1. *Establish a procedure whereby the first step in the processing system is a screening determination of coverage and segregation of documents by Plans I, II, or Plan III.*

2. *Request the National Council on Compensation Insurance to assist in the review and revision of the file and document processing systems currently employed by the division.*

Employee Training

Employees learn their jobs and duties primarily through experience without any written guidelines or procedures. On-going training programs and staff meetings are not conducted to teach employees their jobs, emphasize the importance of the processing function, resolve problems, solicit suggestions for improvements, etc.

Duties are not clearly defined in writing and employees perform duties which are assigned to others. For example, one employee was responsible for searching the employee accident file to determine whether the accident had been assigned a number. However, we noted on several occasions other employees carrying unnumbered documents, searching the same file for the same purpose after the document had already been through the process.

We also noted documents containing as high as six different initials of employees working in the processing function, which indicates that many steps were performed. Some processing steps were duplicated. The length of time taken for six different employees to handle, review, and search files with the same document cannot be determined, but the duplication of review and the delay in processing cannot be disputed.

During the course of our audit we discussed the processing system with employees. Several employees expressed dissatisfaction with the supervision and they expressed concern that they were not sure what duties they were required to perform.

The division should provide training, staff meetings, and written guidelines and procedures. Employees should be informed of their specific duties and responsibilities and made aware of the relationships between their jobs and other functions within the organization.

RECOMMENDATION

We recommend that the division:

1. *Prepare and disseminate written procedures and guidelines governing the duties and responsibilities of all employees.*
2. *Conduct periodic training programs and staff meetings.*

DELIVERY OF COMPENSATION

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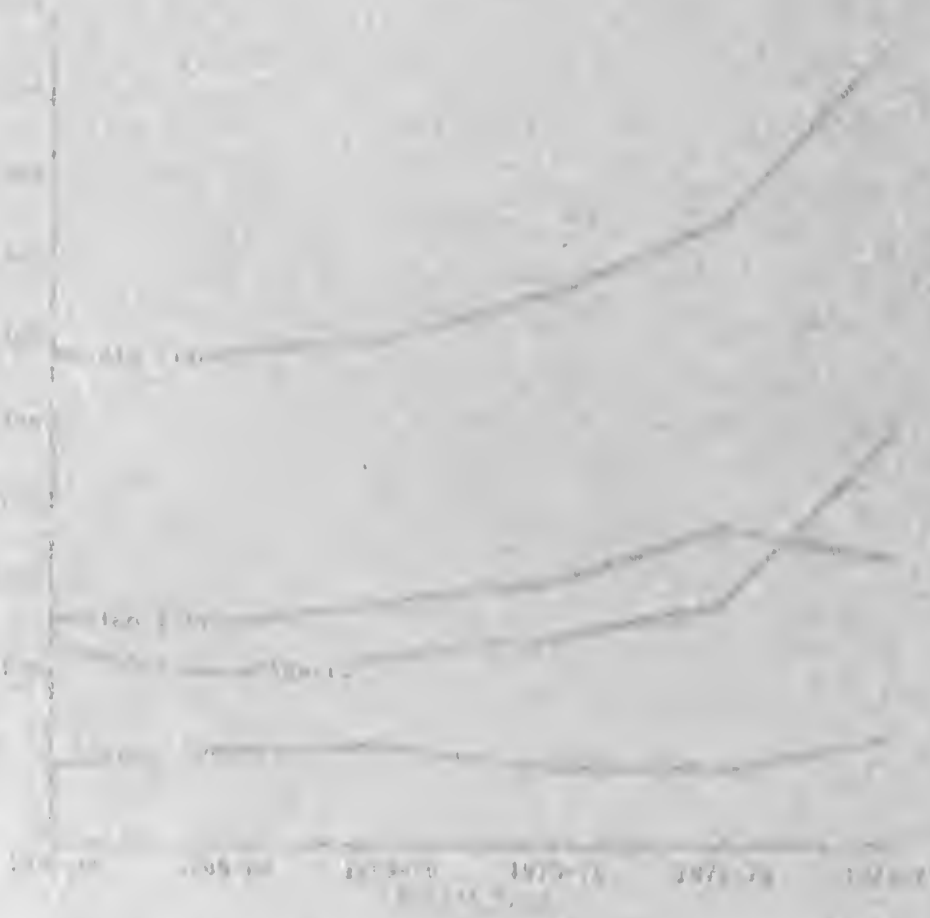


DELIVERY OF COMPENSATION

As described in the preceding sections of the report, workmen's compensation benefits are provided under three plans, i.e., self-insurance (Plan I), commercial insurance (Plan II), and the state insurance program (Plan III). Although employers under Plan I, and insurance companies under Plan II, are primarily responsible for the delivery of benefits under these respective plans, the division has the broad responsibility to see that benefits are properly and promptly paid. Consequently, the division maintains records which depict the manner in which benefits are paid under Plans I and II. In contrast, the division is primarily responsible for the payment of benefits under Plan III, the state insurance program.

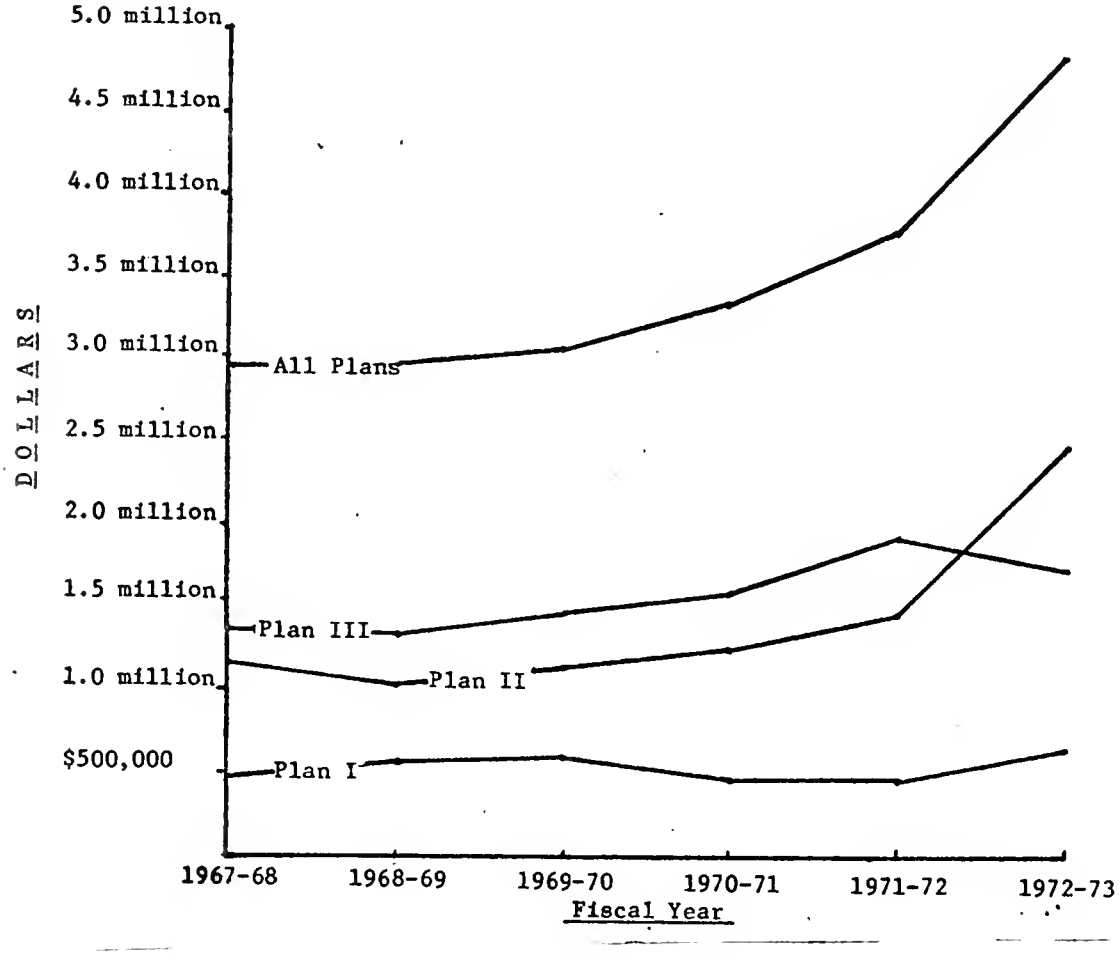
According to the 1972 report of the National Commission on State Workmen's Compensation Laws, the basic objective of a modern workmen's compensation insurance program is to provide protection to workers against losses due to work-related injuries or disease. The delivery of this protection is the sum total purpose of the workmen's compensation insurance program. In Montana, as in most other states, the protection is delivered to the injured employees in two general forms: (1) medical payments, and (2) disability compensation payments.

Medical payments consist of direct payments made to physicians, pharmacists, hospitals, etc., on behalf of injured employees. These payments are made by the employer under Plan I, the insurance companies under Plan II, and the state insurance program under Plan III. According to Section 92-706.1, R.C.M. 1947, all reasonable medical services are provided for three years after the injury occurs. The payment of medical benefits has no effect on the injured employee's eligibility for disability compensation. During 1972-73, about $4.8 million in medical payments were made under all three

plans on behalf of injured employees. The following graph depicts the level of medical payments during the last six years:

TOTAL MEDICAL BENEFITS PAID

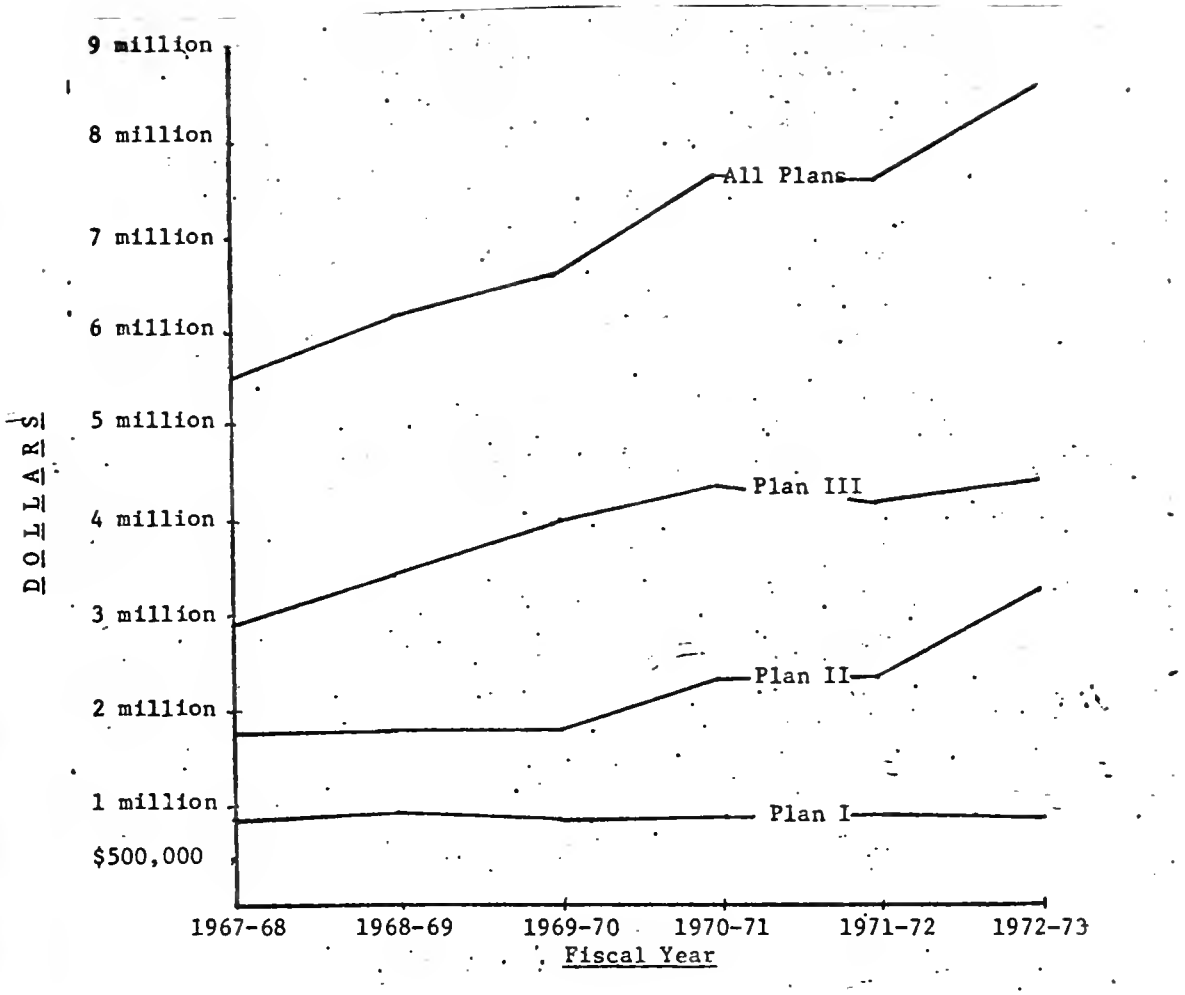
ALL PLANS



The second form of benefits is disability compensation payments, generally referred to as "compensation payments." Compensation payments form the primary protection against lost income to injured workers and constitute the most significant form of workmen's compensation benefits. During 1972-73, over $8.5 million was paid in compensation payments under the three plans administered by the division. The level of compensation payments during the last six years is depicted by the following graph:

TOTAL DISABILITY COMPENSATION PAID

ALL PLANS



Disability compensation payments can be made in two basic forms, either bi-weekly or lump-sum. Bi-weekly payments made each two weeks are intended to compensate the injured employee while he is unable to work or able to work only at a reduced capacity. Lump-sum payments are single, one-time payments to the injured employee in lieu of bi-weekly payments. There are four types of lump-sum payments, as follows:

1. Compromise and Release Agreements: (Also referred to as full and final compromise settlements). In return for a sum of money

agreed upon by both the insurer and the claimant, the insurer is relieved of future liability and the claimant gives up his rights to additional benefits. This type of settlement arises out of a dispute or controversy between the claimant, employer, and insurer over liability or amount and form of payment. The claimant may retain his right to medical benefits; however, the claim may not be reopened if the same injury becomes worse at a later date.

2. Non-Acceptance Settlement: Similar to a compromise and release agreement in circumstances and nature; however, the insurer or employer does not accept liability for the accident. Payment is made by the employer or on his behalf by the insurer to resolve the controversy over liability.
3. Final Settlement: A lump-sum payment made in full settlement of a claim. If the degree of injury changes or becomes worse, the claimant may reopen the case and apply for further benefits within four years after the award.
4. Partial Lump-Sum Advance: A lump-sum payment made against future benefits when the claimant demonstrates financial need. The number of weeks of compensation the worker is entitled to is proportionally reduced by the amount of the award.

Irrespective of the form of payment, the actual amount of payments to injured employees is largely governed by state law. In this connection, the provisions of law are complex and interwoven with the rulings of judicial bodies. Although the law is complex, it can be simply stated that the amount of disability payments is based upon level of wages earned prior to the injury, wages lost, and loss of potential earning capacity.

Aside from death, for which benefits are governed by law, injuries to employees fall into three general categories, all of which are defined by law and governed by law insofar as benefits are concerned. These categories are (1) temporary total disability, (2) permanent partial disability, and (3) permanent total disability.

Typically, a worker injured on the job and completely disabled for several months would be temporary totally disabled. He would receive bi-weekly compensation amounting to 2/3 of the wages received at the time of the injury, subject to a current maximum of $110 per week. These payments continue until the injured employee returns to work or is declared permanently totally disabled.

If the worker is unable to return to his former employment but obtains other employment, further compensation could be paid based upon 2/3 of the difference between his pre-injury wage and present wage, up to a period of 500 weeks.

If the injured worker is never able to return to his job and has no reasonable prospect of finding alternative employment, he would be considered permanent totally disabled and would be entitled to compensation payments in the amount of 2/3 of his pre-injury wages subject to a limit equivalent to the average weekly wage within the state. These payments would continue so long as the injured employee is permanent totally disabled.

Even if a worker has no actual loss of wages, he may be eligible for compensation due to impairment through the loss of a bodily motion or function. Impairment benefits in this category are based upon a statutory schedule that enumerates the various types of injuries and prescribes the number of weeks of compensation to be paid. For example, the loss of: one arm at or near shoulder....280 weeks; one arm at the elbow....240 weeks; one arm between the wrist and elbow....220 weeks.

Other injuries not enumerated on the schedule are related to the schedule by use of an impairment rating, assigned by a physician. For example, a 10 percent loss of function or motion due to a back injury may result in 50 weeks of payment. This amount is determined by multiplying 10 percent times 500 weeks. The period of 500 weeks is the statutory equivalent of total disability.

LUMP-SUM SETTLEMENTS

As previously mentioned, compensation payments can be made either bi-weekly or in a lump-sum. In this connection, Section 92-714, R.C.M. 1947, stipulates that all compensation payments shall be made at the end of each two-week period except as otherwise provided by law. The exception and basis for lump-sum settlements is established by Section 92-715, R.C.M. 1947, which provides that bi-weekly payments may be converted into a lump-sum payment. The pertinent provisions of Section 92-715 are as follows:

> "The bi-weekly payments . . . may be converted, in whole or part, into a lump-sum payment . . . . Such conversion . . . shall rest in the discretion of the (division), both as to the amount of such lump-sum payment and the advisability of such conversion. The (division) is . . . vested with full power, authority, and jurisdiction to compromise claims and approve compromises of claims . . . . Any approval of the (division) must be in writing and set forth specifically the reasons for such lump-sum or compromise payment."

Although Section 92-715 clearly establishes the authority of the division to make lump-sum settlements, Montana court rulings have just as clearly circumscribed the purpose and use of lump-sum settlements. For example, one ruling by the Montana Supreme Court in 1932 declared that the intention of the Legislature in enacting the Workmen's Compensation Act was that periodical payments should be the rule and lump-sum settlements the exception. (Davis vs Industrial Accident Board 92 M 503, 507, 15 P 2d 919). Similar rationale has also been presented in other rulings.

Irrespective of the legal aspects, payments on a period basis are more logical than lump-sum payments from the standpoint that the workmen's compensation insurance program is basically an income maintenance program. It is designed to compensate and, in a sense, replace the income lost or potentially lost due to an industrial injury. This philosophy is recognized by the Montana Supreme Court in Laukaitis vs. Sisters of Charity 135 M469, 342 P 2d 752 (1959) wherein the court declared that the purpose of the periodic payments is, as far as possible, to preclude the possibility of an improvident claimant wasting the means of support.

Notwithstanding the view that lump-sum settlements should be the exception rather than the rule, our review disclosed that lump-sum payments are a common practice in Montana. Our analysis of claim payments made during the three and one-half year period of January 1, 1970, through June 30, 1973, disclosed that over one/third of the claims and almost 60 percent of the dollar payments were made in the form of lump-sum settlements. The extent to which payments and claims were comprised of lump-sum settlements is depicted in the following table:

VOLUME OF CLAIMS AND LUMP-SUM SETTLEMENTS
ALL PLANS
January 1, 1970 through June 30, 1973

	Number of Claims			
	Plan I	Plan II	Plan III	Total
Claims Paid	2,243	5,077	5,719	13,039
Claims Settled as Lump-Sum	522	1,772	2,142	4,436
Percent Settled as Lump-Sum	23.3	34.9	37.5	34
	Dollar Amount			
Total Compensation Paid	$3,156,579	$8,461,382	$14,937,708	$26,555,669
Compensation Paid as Lump-Sum	1,668,111	5,223,893	8,766,583	15,658,587
Percent of Compensation Paid as Lump-Sum	52.8	61.7	58.7	59.0

The propriety and basis for these lump-sum settlements is difficult to discern from the claim files because of the absence of documentation as to the reasons for such payments. As previously mentioned, Section 92-715, R.C.M. 1947, specifically requires that the administrator set forth in writing the specific reasons for lump-sum settlements.

Nevertheless, the claim files underlying the settlements made during the three and one-half year period ending June 30, 1973, included little, if any, documentation of the basis for lump-sum settlements as opposed to routine bi-weekly payments. Consequently, it cannot be ascertained from the claim whether a lump-sum settlement was in the best interest of the claimant. The absence of documentation is illustrated by the following example in which an attorney representing a claimant addressed a letter to the former administrator stating, "Pursuant to our settlement negotiations, I have enclosed the petition for compromise settlement for my client . . . ." The administrator responded with a handwritten memo stating, "Order per petition." Shortly thereafter a warrant for $9,250 was sent to the attorney on behalf of the claimant. These two memos were the only documentation in the claim file concerning the lump-sum settlement.

Claims were regularly settled on a lump-sum basis with no mention in the file of how such a settlement was reached or how it would affect the best interest of the claimant. Claim files were so lacking in documentation of reasons leading to lump-sum settlements it was necessary for us to ask the present administrator and the legal counsel for possible reasons why lump-sum settlements were made. These officials enumerated six reasons why a claim would ordinarily be settled through use of a lump-sum payment as follows:

1. Compensation payments are not always adequate to support a family, so the claimant requests an advance to consolidate bills.
2. The claimant can be rehabilitated by using lump-sum payment to purchase a business.
3. Some of the awards are relatively small in terms of dollars, and extended periodic payment makes little sense.
4. The case is compromised to avoid court proceedings with possible establishment of unfavorable case law.
5. Some claimants would rather have an immediate lump-sum rather than receiving a larger amount in the form of bi-weekly payments.
6. Compensation is based upon a specific impairment and payment is made in accordance with the schedule prescribed by statute. Consequently, they said there is little sense in making periodic payments in lieu of lump-sum payments.

In contrast to the practice in Montana, the State of Arizona, which is similar in operation to workmen's compensation in Montana, does not allow lump-sum payments except in those instances where an injured employee:

1. Demonstrates that he is dying of unrelated causes and desires the benefits for that reason.
2. Demonstrates that he intends to purchase a business which will provide him with an alternate source of income.
3. Intends to leave the state in pursuit of a business or alternate form of living.

In Montana, the reasons for lump-sum settlements are rarely spelled out in the claim files except in those instances where a claimant bought a small

business or sought an advance to consolidate bills.

Although there are several different types of lump-sum settlements, the majority of lump-sum payments were full and final compromise settlements. The comparative level and extent of full and final compromise settlements during 1972-73 are depicted in the following table:

	Plan I		Plan II		Plan III		Total		Percent	
	Cases	Dollars	Cases	Dollars	Cases	Dollars	Cases	Dollars	Cases	Dollars
Full and Final Compromise Settlements	98	$307,682	441	$1,427,072	474	$2,085,887	1,013	$3,820,641	78%	81%
Final Settlements	31	100,914	53	130,364	117	473,007	201	704,284	15%	15%
Partial Lump-Sum	5	4,286	24	15,944	65	160,933	94	181,163	7%	4%
Total Lump-Sum Settlements	134	$412,882	518	$1,573,380	656	$2,719,827	1,308	$4,706,088	100%	100%

It is obvious that full and final compromise settlements comprise the largest number of lump-sum payments on both a claim and dollar basis. The National Commission on State Workmen's Compensation Laws found that full and final compromise settlements are one of the most controversial aspects of workmen's compensation programs.

The national commission's report expressed the belief that use of full and final compromise settlements is not consistent with the purposes of workmen's compensation insurance programs and that when faced with a legal document such as a compromise and release agreement, few employees feel capable of evaluating their rights without the aid of an attorney. The national commission stated that the main virtues of full and final compromise settlements were the termination of employer and insurer responsibility and the reduction of administrative work for the state agency, both of which were not adequate justification for a procedure which deprives the employee of his rights to equitable compensation.

The effect of lump-sum settlements in Montana generally conforms to the findings of the national commission. Lump-sum settlements embody the

primary area of past controversy within the division. Many instances of apparent adverse effects were found in the review of claims which were settled by lump-sum procedures. Some of the effects of lump-sum settlements are illustrated by the following examples:

Example A: A claimant was injured in 1970, and received bi-weekly compensation payments through 1972, when the case was settled by a compromise and release agreement. In a letter to the administrator, the attorney representing the claimant, recommended a lump-sum settlement of $9,500 "before he decides to reenter a hospital or seek additional medical treatment, etc." The settlement was made in July, 1972. In October, 1973, a physician's report stated that the claimant had been under the physician's care for the past year and that the claimant's condition has remained stable with definitely no improvement.

If this case had not been settled by compromise, the claimant's medical bills would have been paid for one more year and he would still be receiving bi-weekly compensation. In addition, he would be eligible for a partial lump-sum advance to consolidate his bills if the need arose.

Example B: The claimant received $33,746 during a 56-month period. This claimant was first injured in 1969, and received $2,300 in bi-weekly compensation and an $11,000 compromise settlement in 1970. The claimant was reinjured in 1971, and received $2,266 in weekly compensation plus an $8,000 compromise settlement. The claimant was again reinjured in 1973, and is presently receiving compensation and, during 1973, received a $7,000 advance to consolidate his bills.

After a compromise and release agreement, the insurer immediately becomes liable for payment in case of reinjury or any new injury. If this claim had been paid bi-weekly rather than periodically settled, cost to the insurer would have been significantly less.

Example C: The claimant received $16,000 from the division between August 31, 1972, and May 1, 1973. Three separate compromise and release agreements for $5,000, $4,500, and $6,500 were negotiated between the claimant's attorney and the former administrator. No reasons were documented for any of these payments.

Lump-sum settlements provide an opportunity for abuse. A recent U. S. Department of Labor study of compromise and release agreements (Compromise and Release Settlements by Louise B. Russell, Economist, U. S. Department of Labor) cites another study made of workmen's compensation (Somers and Somers, 1954) which found that compromise and release settlements provide undesirable incentives to all parties involved in workmen's compensation. The Somers and Somers study stated that:

> "Lump sum payments are associated with the worst abuses found in workmen's compensation: As presently practiced, commutation usually involves a 'compromise settlement,' i.e., settlement for less than the total a claimant would receive through periodic payments if his claim were validated, and thus opens up a profitable avenue of 'claims paring' by carriers and employers. 'Ambulance chasing' by lawyers, medical malpractices, and malingering by workers are induced by the attraction of a single large sum of money."

Although the foregoing may not be totally applicable in Montana, we did find strong evidence to indicate the presence of similar abuses. At the outset of our audit we sent confirmation questionnaires to all claimants who had claims settled on a final and/or full and final compromise basis during the period January 1, 1970, through June 30, 1973. The purpose of our questionnaire was twofold: (1) to confirm information already in the

claim files, and (2) to obtain additional information for use in evaluating the benefit delivery system. We sent out 2,024 questionnaires, of which 824 (41 percent) questionnaires were returned to us in a usable form. A tabulation of the questionnaires sent and returned is shown on Exhibit F on page 149.

The questionnaires returned to us disclosed a myriad of problems associated with lump-sum settlements. Some of the questionnaires reflected information which contradicted the information shown in the claim files, while other questionnaires reflected that many claimants had unusual experiences in conjunction with their claims and lump-sum settlements.

Because of the problems, contradiction in information, and unusual circumstances reflected in many of the questionnaires, we personally interviewed 110 claimants to obtain additional information. Instead of resolving questions, our interviews with claimants presented us with additional contradictions, unusual circumstances, and the possibility of unethical conduct and violations of the penal codes. Much of what was a mere indication of problems on the returned questionnaires was substantiated in our interviews with claimants.

Inasmuch as many of the problems disclosed by our review of this area may constitute violations of the penal codes, we have notified the Attorney General pursuant to Section 79-2308, R.C.M. 1947. Since these and related matters are presently under investigation by the Attorney General, details of our findings are not included here, but will be presented in a supplementary report. A summary list of these matters is presented on page 125.

It cannot be determined to what extent the lure of large settlements had in creating the apparent abuses; however, without the lure of lump-sums, many of the apparent abuses would be corrected. The fact that numerous abuses are apparent and a full-scale investigation is underway exemplifies the statement made in the U. S. Department of Labor's report ". . . that compromise and release settlements provide undesirable incentives to all parties involved."

Consequently, procedures should be established to discourage full and final compromise and limit the use of other types of lump-sum settlements to those instances where written application is made by the claimant and it is clearly demonstrated that such a payment is solely in the best interest of the injured employee.

The entire burden of proof to demonstrate betterment and rehabilitation through a lump-sum settlement is on the injured employee inasmuch as such a request constitutes an exception to the rule. This is a requirement in Arizona and is also a requirement of law in Montana. In these cases, the basis and justification for a lump-sum settlement in lieu of bi-weekly payments should be specifically documented as required by law and not merely passed off as being in the best interest of the injured employee.

RECOMMENDATION

We recommend that the division:

1. *Limit the use of lump-sum settlements to those instances where claimants demonstrate that such a settlement is in their best interest from the standpoint of betterment and rehabilitation.*
2. *Specifically document the basis and justification for lump-sum settlements as required by Section 92-715, R.C.M. 1947.*

AUTHORITY OF ADMINISTRATOR

The administrator of the Workmen's Compensation Division is vested with full authority to award compensation, settle claims, or increase or diminish an award. The law is specific in this regard. Section 92-715, R.C.M. 1947, provides that:

> "The board is hereby vested with full power, authority, and jurisdiction to compromise claims . . . and all settlements and compromises . . . shall be null and void without the approval of the board."

Section 92-824, R.C.M. 1947, states that:

> "The board in its award may fix and determine the total amount of compensation to be paid, and specify the manner of payment."

The Industrial Accident Board no longer exists. Executive reorganization, of the Department of Labor and Industry, effective December 13, 1971, transferred all powers to the division. In effect, the word "division" may be substituted for board wherever it appears in the statutes.

Prior to executive reorganization, a three-man Industrial Accident Board met weekly to rule on settlements. The board approval was required on all settlements. The administrator acted as chairman. The former administrator, and chairman of the board, stated that every case adjudicated by the board "was thoroughly discussed by the board members that were present at the time." The board considered an average of 40 claims each week, with as many as 75 claims in some weeks. Comments by the other two members of the board are at variance with those of the former chairman. They both note that the limited 2-3 hour sessions each week and the large volume of claims necessitated a cursory review. Essentially, the board met only to approve the actions of the administrator and to sign the board orders. Consequently, the actions of the board were more or less "rubber-stamp" endorsements of the chairman's decisions.

The effect of executive reorganization was negligible. The only real effect was that the signature of the administrator on an order became sufficient

instead of three signatures of board members, as was formerly required. Formal approval of the administrator's action by the board was no longer required.

After reorganization, a claims review committee was formed, consisting of the chief of the state fund, claims examiners, and field representatives. This committee met weekly to discuss Plan III cases and settlements; however, like a private insurer, their decisions were subject to approval of the administrator. In most instances, if the claimant was represented by an attorney, the committee was by-passed. Any correspondence or negotiation concerning that claim was handled directly by the administrator without the involvement of the claims review committee. Frequently, the members of the claims review committee would never see a case until after it was settled by the administrator.

Our review of claims settled in all three plans revealed numerous problem areas. These problems stem directly from the fact that the former administrator settled claims on his own. We found that:

1. Claims were settled after the statutory time limit.
2. There was a general lack of documentation supporting settlement of claims as required by law.
3. The information gathering and investigative functions of the division were circumvented, with the result that some cases were settled under highly unusual circumstances.
4. Through direct access to the administrator, attorneys were able to obtain settlements significantly larger than claimants who were not represented by attorneys.

We found that claims were settled by the administrator in violation of the time frame stipulated by law. Section 92-601, R.C.M. 1947, states:

"In case of personal injury or death, all claims shall be forever barred unless presented in writing to the employer, the insurer or the division, as the case may be, within twelve (12) months from the date of the happening of the accident, either by the claimant or someone legally authorized to act on his behalf."

In July, 1973, the following addition became effective:

"The division may, upon a reasonable showing by the claimant of lack of knowledge of disability, waive the time requirements up to an additional twenty-four (24) months."

The claims encompassed by our review consisted of claims settled before July 1, 1973. Consequently, the above addition was not in effect.

We found claims that were settled by the administrator after the statutory period for submission of a claim had expired. Rather than the law being the guide to which claims should be accepted, we noted that the administrator's decision to accept or reject claims was the deciding factor.

The division's legal counsel informed us that a legal concept (referred to as the doctrine of equitable estoppel) often allows a claimant to submit a claim after the statutory period. As defined by the Montana Supreme Court (Levo V. Gen. Shea - Morrison, 128 M 570, 280, P 2d, 1086-1090) equitable estoppel's main objective is preventing a party from taking unconscionable advantage of his own wrong while asserting his strict legal right.

A recent court case, decided July 26, 1973 (Ricks vs Teslow Consolidated and Argonaut Ins. Co., Stated Reporter V30, No. 12419) noted that estoppel applies "only where there has been affirmative acts before the statutory period has run which either prevent the claimant from filing or lead him to believe he need not do so." We noted two instances where a claimant's attorney informed the division that his client had not submitted a claim for compensation because his employer informed him that he need not do so. However, in these instances, the division's records contain no documentation of an attempt by division personnel to verify that the claimant was in fact misled by his employer.

Documentation supporting settlement of claims was generally inadequate. Over one-half of the 2,800 claims directly settled or approved by the administrator did not have documentation sufficient to disclose the reasons why a settlement of the claims was made even though such documentation is required by law. Section 92-715, R.C.M. 1947, states that approval of settlements and compromises must be in writing and must set forth specifically the reasons for such lump-sum or compromise payment. As discussed in a previous section of the report (Use of Lump-Sum Settlement Procedures) there are very few instances where the claim files indicate the reasons for settlement of the claim, and in many cases it cannot be ascertained at all why the administrator took the action he did. For example, in one case, the claims review committee recommended to the administrator that a settlement of $250 be made. The claims review committee adhered to this recommendation even after consulting with the claimant's attorney. Consequently, the attorney contacted the administrator and a memo in the claim file from the administrator states, "contacted this date by attorney (name deleted) and after some discussion over the problem of disability from the later part of December, 1971 to the current and the claimant's permanent partial disability, an offer was made to settle the entire amount on a compromise basis for $3,500." The file gives no indication as to how a settlement was reached at $3,500 just 43 days after the claims review committee stood firm on its offer of $250.

In another case, the claimant was injured in a bar fight. The field representative who investigated the case recommended that the claim be denied because it was not connected with her regular employment and appeared to be a grudge fight. The file contains no evidence of impairment or disability. Four and one-half months after the incident the claimant received a settlement of $2,500. The present administrator, after review of the above file,

advised us that the file did not contain sufficient information to warrant a settlement. He stated that he would not have settled the case without further investigation.

Cases such as this demonstrate the lack of documentation contained in some files. Some settlements may have been reasonable, but this cannot be determined since the files contain no documents supporting a settlement.

We also noted many cases where the hearing procedures were not used and field representatives did not investigate to develop the facts surrounding claims eventually settled by the administrator. The absence of these procedures was a common practice in these claims handled directly by the administrator.

For example, one claim was initially denied because it was not a work-related injury. The claimant had informed his doctor that he hurt himself digging fence post holes at home. The claim for compensation was submitted nine years after the injury. The administrator settled the claim for $4,500, even though the file contains conflicting information about the date and nature of the injury. A formal hearing could have developed the facts surrounding the case.

In cases where attorneys represented claimants, less than half of the claims were investigated by division field representatives. In contrast, claimants who chose not to be represented by an attorney were usually contacted by field representatives, and settlement was reached only after review and approval by the claims review committee and final approval of the administrator.

Our analysis of claims also disclosed that attorneys were able to deal directly with the administrator and obtain settlements which were significantly larger than those instances where attorneys were not used. Our analysis of over 2,800 claims settled directly or approved by the administrator disclosed that settlements for some type of injuries were substantially higher when attorneys dealt with the administrator than those instances where attorneys were not involved. Under ordinary circumstances, this would not be considered unusual, however, in these instances, the attorneys dealt directly with the administrator and by-passed the regular channels within the division.

The administrator should not be technically involved in the day-to-day operations of the division. It is unreasonable to expect the administrator to adequately perform his job as the chief executive of an agency, and at the same time make technical decisions with respect to individual claims which are the routine business of the division. The routine business decisions should be the responsibility of technicians within the division who are hired, trained, and experienced for the purpose of making such decisions. In contrast, it is highly unlikely that a president, or even vice president, of an insurance company would spend any significant amount of time reviewing and making decisions with respect to individual claims. The president certainly would not personally review and sign each decision. These matters would all be handled within a system by technicians and officials. The situation should be the same in the case of the division, but it is not. In many cases, settlements of claims completely bypassed the system and were handled exclusively by the administrator.

The procedures of the division should be changed. The insurance operations of the division should be divorced from the operations pertaining to the general administration of the workmen's compensation laws. This aspect is discussed more fully in a subsequent section of the report dealing with "Agency Organization." In addition, procedures should be established

whereby all compromise payments and lump-sum payments from the state insurance fund are the product of a routine and methodical system of evaluation and decision by technicians. However, the administrator of the state insurance program would have overall responsibility for the program.

RECOMMENDATION

We recommend that the state insurance program establish procedures whereby all compromise payments and lump-sum payments result from a routine and methodical process of evaluation and decision within the state insurance program.

MEDICAL REVIEW

Much of the division's activities involve workmen who have been injured, and there are several areas where medical aspects are involved. The benefits provided injured workmen include payment of medical expenses, such as services of physicians, hospitals, pharmacists, etc. The division reviews the billings submitted from these sources and makes payments on behalf of the injured workmen. The propriety and effectiveness of this program was not encompassed by our review. Rather, our review included only those medical reports associated with claims which were eventually settled.

The division is also involved with injured workmen from a medical standpoint in the area of medical examinations and evaluations. Many of the benefits due injured workmen, particularly where settlements are involved, are based upon medical examinations and evaluations. These medical examinations and evaluations are made by physicians engaged by injured workmen and their attorneys and by physicians engaged by the division as consultants. In these cases, the role of the physician is to provide expert opinion as to the extent and physiological effect of injuries suffered by workmen. This opinion is used by the division and insurers to determine the type of workmen's compensation benefits to which the injured workmen are entitled.

The concepts of "impairment" and "disability" are significant within the context of workmen's compensation insurance. According to the American Medical Association (Amercian Medical Association Guides to the Evaluation of Permanent Impairments, referred to as the "JAMA guide").

"Impairment is a purely medical condition; it is any anatomic or functional abnormality or loss. Disability is not a purely medical condition. A worker is disabled when his actual or presumed ability to engage in gainful employment activity is reduced because of an impairment. The extent of disability may depend upon the interaction of non-medical factors such as age and education."

The differences between impairment and disability are illustrated by the following example: A concert pianist and a truck driver who both lose use of a little finger have the same medical impairment. However, the concert pianist will almost certainly have a greater disability because his ability to perform his employment is reduced to a greater extent than the truck driver. The point illustrated is that subjective factors such as the individual person involved and the effect of the injury on that individual must be considered in arriving at the disability.

Under the workmen's compensation program, impairment ratings are determined by physicians in terms of a percentage, such as 10 percent impairment of the right arm. Guidelines for these ratings are provided for in the JAMA guide. The Workmen's Compensation Division published a booklet entitled Medical Service Rules, which recommends that injuries be rated in percentages as provided by the JAMA guide. The booklet has been effective since July 1, 1973, and past policy of the division has been to prefer ratings based upon the JAMA guide.

Workmen's compensation payments are made to injured employees for impairments and disabilities under several sections of law encompassed by Chapter 7 of Title 92, R.C.M. 1947. Section 92-709, R.C.M. 1947, requires payment of a specified number of weeks of compensation for certain injuries, such as loss of a foot, hand, or fingers. Other permanent injuries, where loss is less than total, are related to the schedule of specific injuries or to the "whole man." The whole man concept is also based upon statute. Since 500 weeks of compensation is the maximum payment for partial disability, 500

weeks of payment equals the whole man. Permanent injuries not included in scheduled injuries are based upon a percentage of 500 weeks of payment. For example, loss of the arm at the elbow requires payment of 240 weeks of compensation. A 50 percent loss of use of the arm at the elbow results in 240 weeks times 50 percent, or 120 weeks of payment.

A back injury that results in a 10 percent impairment to the whole man results in payment of 10 percent of 500 weeks, or 50 weeks of compensation.

The amount of each weekly payment for such permanent injuries is based upon 66-2/3 percent of the worker's weekly wage, subject to a maximum of $60 per week. For example, the worker with a 10 percent impairment to the "whole man" would receive 50 weeks of compensation at $60 per week if he qualified for the maximum amount. If the payment were given in a lump-sum, he would receive $3,000.

Although the JAMA guides are widely used by physicians and insurers throughout the country and in Montana, the division does not require that medical evaluations of injured employees be based upon the JAMA guides or similar uniform impairment criteria. As a consequence, many of the medical reports received by the division are based upon criteria other than the JAMA guides, resulting in variances in interpretation and meaning. Some physicians rate impairment according to other guides, such as:

1. McBride's Disability Evaluation.
2. Manual for Orthopedic Surgeons in Evaluating Permanant Physical Impairment.
3. Evaluation of Industrial Disability.

Some physicians rate the disability rather than the impairment. One physician rates the disability of injured workers on an "occupational grading basis," which is a criteria unknown to officials of the division. In many instances, it appears that physicians are combining the impairment and disability concepts in the reports submitted to the division.

The present administrator informed us that his policy is to accept all medical reports, whether based upon disability or impairment. If the rating seems excessive in relation to the type of injury, he requests a second medical opinion from another physician. Through negotiations with the claimant or his attorney, a compromise impairment rating or dollar amount of settlement is reached.

For example, in the case of one claimant a physician engaged by an attorney examined an injured employee and reported a 100 percent disability. The present administrator requested a second opinion, and directed the claimant to visit a physician engaged by the division. The second opinion stated, "I find no objective evidence of any permanent impairment. Likewise, I do not think any treatment is indicated." Nevertheless, the claimant received a payment of $1,000, which represented a compromise between the two medical reports of 100 percent and zero. The compromise was resolved significantly in favor of the division since a 100 percent rating represented a potential award of 500 weeks of compensation. The actual payment represents 27 weeks of compensation.

Physicians who use a liberal rating method report higher ratings than physicians who use the JAMA guides. Obtaining a higher percentage impairment or disability rating can mean significantly larger settlements. A 5 percent increase in the impairment rating accepted by the division can mean up to $1,500 more in the award.

As shown in the following table, 10 Montana physicians provided over 40 percent of the medical evaluations sought by attorneys.

MEDICAL EVALUATIONS REQUESTED
BY ATTORNEYS
January 1, 1970 through June 30, 1973

Physician	Number of Cases Evaluated at Request of Attorney
A	126
B	89
C	57
D	53
E	40
F	38
G	37
H	35
I	27
J	18
10 Physicians	520 Cases

Workmen's Compensation Cases Handled by Attorneys 1/1/70 to 6/30/73 - 1,242.

Percent Handled by the Above 10 Physicians - 520/1,242 = 41%.

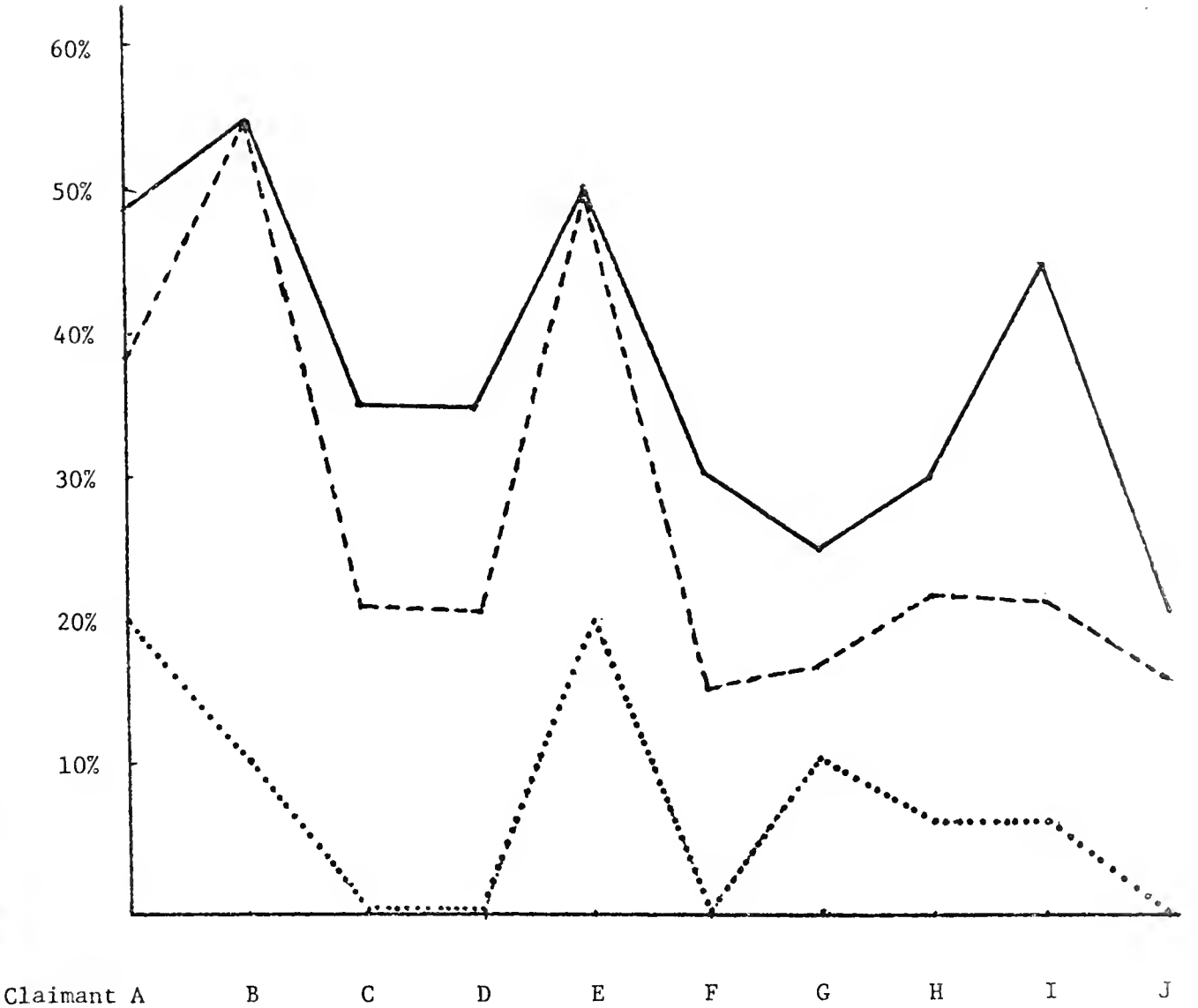
The physician represented by example A in the preceding table provided medical evaluations to 20 attorneys from seven cities. According to division personnel, this physician was selected by the attorneys to a large degree because of his liberal attitude in rendering impairment evaluations.

Officials of the division frequently requested second opinions from physicians with more conservative views in order to offset what they considered high ratings. Alternately, attorneys frequently sent their clients for second opinions to counter ratings they felt were too low. It may be a good practice for the division to routinely seek a second medical opinion whenever attorneys obtain second opinions on their clients.

The advantages of obtaining a second medical opinion are shown in the following graph, based on 10 cases selected for purposes of illustration.

WORKMEN'S COMPENSATION DIVISION

COMPARISON OF IMPAIMENT RATINGS
BY ATTORNEY'S PHYSICIAN, DIVISION PHYSICIAN
AND ACTUAL PERCENTAGE AWARDED



_____ Percentage impairment or disability given by physician at the request of claimant's attorney.

..... Percentage impairment or disability given by physician at the request of the Workmen's Compensation Division.

-------- Actual percentage awarded to claimant.

In the ten cases represented on the graph, physicians performing evaluations at the request of attorneys reported an average impairment or disability of 37.5 percent. In contrast, physicians performing evaluations at the request of the division reported an average impairment or disability of 7 percent. The average award actually received by the claimant equaled 28.9 percent, illustrating the compromise aspect.

Translating these percentages to dollars reveals that the actual lump-sum awards to the ten workers totaled $64,000. If reports from physicians who prepared evaluations at the request of attorneys were accepted, the payment would have totaled $83,000. Similarly, if the reports issued by physicians at the request of the division had been accepted, payments would have totaled $15,500.

We also noted cases where no second medical opinion was solicited by the division. In the case of the physician referred to as Physician A in the preceding table, who submitted 126 medical reports for attorneys during the period covered by our review, only 38 second opinions were requested by the division. This physician graded upon an "occupational grading of permanent disability." We were informed by division officials that, rather than obtain a second opinion, reports from such physicians are discounted or downgraded by the division.

Although not formalized in writing, the downgrading procedures were explained to us. A 60 percent rating by some physicians is discounted to obtain a "reasonable" percentage, say 10 or 20 percent. The officials informed us that they are aware of how various physicians rate, and even though the medical reports are accepted, the actual settlement figure will be lower than that reported by the physician.

Division personnel informed us that they feel obliged to accept all medical reports, regardless of the rating system used by the physician. They expressed

the belief that any attempt to reject medical reports or to impose a uniform rating system upon the physicians submitting the reports would result in a court test, which division officials believe they would lose. They expressed the belief that requesting a second medical opinion or discounting a medical report are satisfactory methods of obtaining a reasonable evaluation.

The present system of accepting any and all medical reports and compromising conflicting medical reports or "discounting" results in four major problems:

1. Personnel of the division without formal medical training and/or experience and with limited access to a medical consultant are placed in the position of having to second guess physicians in (a) interpreting medical reports and (b) discounting or downgrading impairment ratings.
2. The presence of high ratings on one hand and low ratings on the other hand results in a compromise process, in which the presumably legitimate compensation due an injured employee is the focal point.
3. If physician reports are excessive and resultant awards high, the costs of workmen's compensation are unnecessarily high.
4. If physician reports are too low, the injured employees are deprived of the benefits prescribed by statute.

Reasonable and equitable administration of the workmen's compensation laws requires that the criteria used in rating impairments be as uniform as possible. The payment of benefits should not depend entirely upon a compromise process involving the rating systems used by various physicians, the judgment of non-medical personnel, and an arbitrary process of discounting or downgrading.

The use of a standard criteria such as the JAMA guides would solve the present problems to a large extent. The JAMA guides are a result of an

exhaustive effort by the American Medical Association to establish and continually revise a series of practical guides for the rating of physical impairments. According to a recent study of workmen's compensation in New Jersey (Report of the New Jersey Workmen's Compensation Study Commission, September 30, 1973), the JAMA guides presently constitute the most authoritative tool available for the determination of permanent impairment. The guides are used exclusively in South Carolina and have been statutorily adopted by Idaho and Nevada. The New Jersey study concluded that the guides would result in relative uniformity in the evaluation of permanent impairment and recommended that the use of the JAMA guides be made mandatory in New Jersey.

The JAMA guides should also be mandatory in Montana. The use of the guides would provide a uniform and well organized basis upon which impairment ratings should be based. This would eliminate use of other bases which may or may not be compatible and would alleviate much of the need for interpretation and adjustment of ratings by laymen. Since there will undoubtedly be instances where the JAMA guides will have no application or will be applied incorrectly by physicians, the division should establish an ongoing peer review process and a medical review panel to provide expert review of medical problems associated with medical evaluations and reports. The peer review process and medical panel could also serve as a means of evaluating the adequacy of medical treatment provided injured workmen. The division should explore the possibility of engaging the services of the Montana Foundation for Medical Care, for the purpose of selective and routine evaluation of medical reports. The Foundation for Medical Care is an affiliate of the Montana Medical Association and is presently providing such evaluative services to the State Department of Social and Rehabilitation Services.

RECOMMENDATION

We recommend that the division:

1. *Formulate regulations requiring the impairment aspect of all ultimate settlements be based upon the American Medical Association Guides to the Evaluation of Permanent Impairment.*
2. *Establish a peer review process to routinely review medical reports and other medical activities of the workmen's compensation insurance program.*
3. *Establish a medical review panel to selectively review controversies arising from the peer review process.*

ATTORNEY SERVICES

As mentioned in the general comments, workmen's compensation programs were generally intended to be self-administering and relatively simple in operation. Over the years, however, the administration and application of the workmen's compensation laws have become complex and involved with medical and legal practices and concepts. As a consequence, the involvement of attorneys in the processing and settlement of workmen's compensation claims is common, not only in Montana, but elsewhere in the country.

It is a general practice of the division to deal exclusively with attorneys engaged by claimants rather than directly with the claimants themselves. Once the division is notified that the claimant has engaged an attorney, the division corresponds, communicates, and negotiates directly with the attorney rather than the claimant. Typically, upon settlement of a claim, the division mails the settlement payment directly to the attorney who deducts his legal fees and gives the remainder of the settlement proceeds to the claimant.

Since the division did not deal directly with claimants who were represented by attorneys, the division did not routinely advise claimants of the fact that their claim was settled by their attorney. However, about the time our review commenced, and because of controversies surrounding the division, the division began to advise claimants of the amount of settlement payments made to attorneys on their behalf. This is done by means of a form letter which is sent directly to the claimants.

Our review of 2,800 claims disclosed that attorneys have a significant role in the workmen's compensation processes. We found that a large part of the workmen's compensation business was handled by relatively few attorneys as indicated by the following table:

ATTORNEYS HANDLING $100,000 OR MORE OF WCD SETTLEMENT CASES UNDER PLAN III JANUARY 1, 1970 THROUGH JUNE 30, 1973

Attorney	Number of Cases	Percent of Cases	Dollars	Percent of Dollars
1	122	5.7%	$ 437,493	5.0%
2	113	5.3%	571,025	6.5%
3	86	4.0%	388,416	4.4%
4	72	3.4%	502,455	5.7%
5	67	3.1%	443,383	5.1%
6	63	2.9%	355,842	4.1%
7	56	2.6%	428,658	4.9%
8	40	1.9%	267,770	3.1%
9	32	1.5%	147,135	1.7%
10	30	1.4%	198,515	2.3%
11	21	1.0%	119,890	1.4%
12	18	.8%	139,287	1.6%
13	18	.8%	107,350	1.2%
14	18	.8%	128,335	1.5%
15	16	.7%	144,840	1.7%
	772	35.9%	$4,380,394	50.2% *

* Represents 50.2% of total dollar settlements under Plan III during period.

Source: Sample taken of attorneys settling at least $100,000 worth of claims for the above period.

Our review of settlements under Plans I and II showed that 37 percent of Plan I and 46 percent of Plan II claim settlements were handled by attorneys. Similarly, our examination of 2,142 lump-sum settlements made by the division under Plan III during the three and one-half year period ending June 30, 1973, disclosed that over 1,272 injured workers, or 59 percent retained attorneys to assist them in pursuing their claims before the division.

The cases handled by attorneys on behalf of claimants during this period for Plan III represents about $6.7 million of the 8.8 million, or 76 percent, of the settlement payments made during the period. Consequently, attorneys handled the majority of claims, insofar as dollar amounts and number of claims are concerned, under Plan III, and a large number of the claims under Plans I and II.

Our review of 2,142 claims settled during the three and one-half year period disclosed the existence of several problems. First, we found the claimants engaged attorneys for several reasons: (1) because they did not know how to proceed with a workmen's compensation claim; (2) they believed the workmen's compensation laws and regulations too confusing and complex; (3) they believed the use of an attorney would produce better results, or (4) they believed they would be unable to obtain satisfactory treatment from the division without an attorney.

The absence of understanding and need for attorneys is also illustrated by the results of our confirmation/questionnaire which are included at Exhibit F on page 149.

We mailed a confirmation/ questionnaire to 2,142 Plan III claimants who received full and final compromise and/or final settlements during the three and one-half year period. Of the total confirmation/questionnaires mailed, 824 were completed and returned to us in usable form indicating the following:

	Number	Percent of Total Respondents
Did not engage an attorney	431	52%
Engaged an attorney	393	48%
Total responding	824	100%

	Number	Percent of Total Respondents
Attorney engaged prior to initial contact with division	111	13.5%
Attorney engaged subsequent to initial contact with division	269	33%
Total responding	380	46.5%
Requested or advised by someone to contact an attorney	133	16%
Not contacted by anyone regarding the hiring of an attorney	644	78%
Total responding	777	94%

Aside from the fact that claimants engaged attorneys in a significant number of instances, the preceding table also indicates that most claimants engaged an attorney after they had already made contact with the division. This would seem to indicate that the claimants were either confused as to how to proceed or dissatisfied with the actions of or results obtained through the division. Both of these aspects showed up on many of the confirmation/ questionnaires which reflected comments by claimants. These comments generally substantiated the fact that claimants do not understand and, in many instances, are dissatisfied with the workmen's compensation program and, as a result, see a need to engage attorneys.

Our analysis of the confirmation/ questionnaires disclosed many instances where the manner in which claims handled by certain attorneys, appeared to have been abused by those attorneys for the apparent purpose of their own monetary gain. Although the majority of discrepancies disclosed by our analysis pertain primarily to a few attorneys, there are indications that other attorneys may have engaged in similar practices. Because of the possibility that these practices may constitute violations of the penal codes, we have advised the Attorney General of our tentative findings which encompass the following areas:

1. Claims filed by attorney without claimant's knowledge.

2. Settlement by attorney without claimant's knowledge.

3. Settlement checks negotiated without claimant's knowledge.

4. Attorney retained entire amount of settlement.

5. Attorney retained major portion of settlement.

6. Alteration of medical disability ratings.

7. Medical reports may have been submitted without physician's knowledge.

8. Medical reports may have been prepared without medical examination of claimant.

9. Firms may have been established only for the purpose of collecting workmen's compensation benefits.

The Attorney General has undertaken an investigation to assess the magnitude of the problems and involvement of other attorneys and to resolve whether criminal prosecution is warranted. Since these matters are under consideration at the present time, specific details are not included herein but will be presented in a supplementary report.

We have also provided the Attorney General with information concerning the use of runners. Some attorneys used agents to seek out and solicit workmen's compensation cases. Inasmuch as this may constitute an unethical practice, we provided the Attorney General with the information we have developed.

California has enacted laws which prohibit the use of runners or agents by attorneys to solicit business. The California law (West's Annual Business & Professional Code, Section 6150-6154) expressly prohibits the use of runners or "cappers" and prescribes a penalty. Similar legislation may be warranted in Montana.

The division has not attempted to control the practice of attorneys in any manner with respect to workmen's compensation claims and has not regulated or controlled attorney fees. In contrast, most other states have

regulated the fees charged by attorneys in conjunction with workmen's compensation cases, as indicated by the following table:

	Number of States	Percent
Regulate attorney fees	42	84%
Do not regulate attorney fees	8	16%
Total	50	100%

The states which do not regulate attorney fees are as follows:

Connecticut	New Hampshire
Iowa	Ohio
MONTANA	Pennsylvania
Nebraska	Washington

Source: Compendium on Workmen's Compensation.

The 42 states which regulate attorney fees do so under authority granted by law. In some instances, the statutes stipulate the allowable level of fees, while in other instances the allowable fees are set by administrative rule or policy. Detailed information on the manner in which attorney fees are regulated in other states is presented in Exhibit G on page 150. The obvious conclusion is that attorney's fees are regulated in nearly all of the states, with one of the few exceptions being Montana.

The reasoning behind regulation of attorney fees in workmen's compensation cases basically relates to the fact that in most cases the liability for job-related injuries is already admitted by virtue of the fact that employers have workmen's compensation insurance. This contrasts with a tort case where determination of liability is often the question and consequently a higher attorney fee is warranted. The fact that liability is already admitted in workmen's compensation cases reduces the services an attorney must perform; consequently, it should reduce the fees charged by the attorney.

We were advised that Section 92-827, R.C.M. 1947, which ostensibly gives the division authority to set attorney fees, applies only if a hearing is held. The division legal counsel stated that the statute does not apply where the case is settled without a hearing. According to division officials, the division does not have the statutory authority to regulate or set attorney fees. Consequently, this has never been done, even though most other states regulate attorney fees as indicated by the preceding table.

However, Section 92-827, R.C.M. 1947, provides in part:

> "Whenever the claimant or plaintiff is represented by an attorney either before the board or the courts, the industrial accident board may, in its discretion or upon application of the claimant or plaintiff, fix the amount of the attorney fee of the attorney representing the claimant or plaintiff, and the fee fixed by the board shall be paid by claimant or plaintiff."

The Montana Supreme Court has considered the application of this statute and in the case of In Re Porter, 156 Mont. 190, 478 P 2d 866, the Court stated:

> "Porter admitted these facts but defended his actions on the ground the Industrial Accident Board had no power to fix attorney's fees and its order was void. However, section 92-827, R.C.M. 1947, as amended, grants this power to the board."

In addition, Section 92-616, R.C.M. 1947, provides in part:

> "In the event the insurer denies the claim for compensation or terminates compensation benefits, and the claim is later adjudged compensable, by the division or on appeal, the insurer shall pay reasonable costs and attorneys' fees as established by the division."

Based on the foregoing, it does appear that the division has the authority to regulate or set attorneys' fees.

The National Commission on State Workmen's Compensation Laws recommends "that attorney fees for all parties be reported for each case, and the fees be regulated under the rule making authority of the workmen's compensation administrator."

In the absence of any regulation, the amounts retained by attorneys have varied from zero to 100 percent of the amount of settlement. There are instances where attorneys have not charged any fees apparently out of friendship or other circumstances. There are also many instances where certain attorneys have retained the entire settlement without the knowledge of the claimants. The specific details with respect to these instances will be presented in the supplementary report.

For the most part, however, fees charged by attorneys range between 20 percent and 40 percent of the amount of settlement, with the most common being 33 percent. The workmen's compensation legal counsel advised us that fees are determined in a variety of ways. Some attorneys charge on an hourly basis, with the resultant fee usually a small percentage of the total settlement. Others charge a contingent fee, based upon the amount of increase in the award they are able to secure. Others charge a flat contingent fee of the amount of the award.

Whatever the method used to determine the fee, it should remain consistent with the goal of workmen's compensation, which is compensating the injured worker. In the average case, injured workers should not have to resort to the use of an attorney to obtain fair treatment under the workmen's compensation laws. If the workmens' compensation program were operating properly, the instances where attorneys are necessary should be infrequent, particularly since liability for payment is not a matter of controversy.

The division should regulate and control the fees paid to attorneys in conjunction with workmen's compensation cases to insure the best interests of the claimants. Regulation of such fees is presently the case in most other states and is a major recommendation of the National Commission on State Workmen's Compensation Laws. The fees allowed by the division should be based upon a fee schedule established by the division in conformance with the requirement of

the Montana Administrative Procedures Act. There should be a hearing involving interested parties and, if appropriate, a formal publishment in the Montana Administrative Register. In addition, the division should establish procedures whereby the fees charged by attorneys are reported to the division for each case. This would enable the division to ascertain that the fees charged are within the limits set by law and regulation.

RECOMMENDATION

We recommend that the division:

1. *Establish a fee schedule governing the attorney fees allowable in conjunction with workmen's compensation cases.*
2. *Establish and periodically modify the fee schedule in accordance with the procedures of the Montana Administrative Procedures Act.*
3. *Establish procedures whereby the amount of attorney fees paid are reported and documented in each workmen's compensation case.*

PRESENT WORTH ADJUSTMENT

Section 92-715, R.C.M. 1947, requires that lump-sum payments "shall not exceed the estimated value of the present worth of the deferred payments capitalized at the rate of two per centum (2%) per annum." This statute considers the present value of money when a lump-sum payment is made, as opposed to deferred payments over a period of time, which is the customary manner of payment.

Capitalizing a lump sum is a relatively simple process. The division has prepared a table of the present value of $1 discounted at 2 percent

simple interest. Multiplying the present value figure times the amount of the settlement yields the proper amount of the lump-sum. The present value concept is common in business and finance. Essentially, it is the price paid for receiving money immediately rather than receiving it at some date in the future. Within the context of workmen's compensation benefits, the amount of capitalized lump-sum will be less than the amount the claimant would receive over a period of time as bi-weekly payments.

We examined over 2,100 lump-sum settlements and failed to find a single one where the 2 percent (present worth adjustment) was used in computing the value of the settlement. For example, in one instance a claimant was awarded $6,000 after negotiations between his attorney and the administrator, the entire $6,000 was paid in a lump-sum. The correct amount of the lump-sum payment should have been $5,886. The claimant should have received the full $6,000 only if the payments were made bi-weekly.

The foregoing example is relatively insignificant in itself, but illustrates the manner and effect of the present worth adjustment. The failure of the division to apply the present worth adjustment is significant from an overall standpoint, however. During the period January 1, 1970, to June 30, 1973, over $8.8 million was disbursed on a lump-sum basis under Plan III by the Workmen's Compensation Division, with over $2.7 million of this amount being disbursed during fiscal year 1972-73. Because of the variance in rates and duration of payments, we have not computed the total amount of overpayment on settlements caused by the division's failure to apply the present worth adjustment required by law. However, the amount overpaid would be significant.

Division personnel advised us that although the present worth adjustment required by law has existed since 1915, it has not been applied for many

years. According to these personnel, the former administrator refused to accept settlements where the present worth adjustment was made. We were advised that a number of Plan II carriers apply the present worth adjustment in making lump-sum payments.

The present worth adjustment required by Section 92-715, R.C.M. 1947, is a sound procedure widely accepted in insurance activities and should be applied as required by law.

RECOMMENDATION

We recommend that the division apply the present worth adjustment to all lump-sum payments as required by Section 92-715, R.C.M. 1947.

PAYMENT OF DISABILITY CLAIMS

The workmen's Compensation Division uses two methods of disbursement--the state claim warrant system and division warrants manually written at the division office. The state claim warrant system is used for paying all administrative costs of the division, all expenditures concerning the silicosis program, all medical payments, and dividend payments. Only disability compensation claims are paid outside of the state's claim warrant system through a manual process involving clerical personnel, typewriters, and soft copy warrants rather than the standard state warrants which are hard copies.

In our previous audit of the division (September 1970) we recommended that a study be made of the problems in obtaining timely payments from the state claim warrant system and that procedures be initiated to use this system as soon as possible. The main objection expressed by the division is that the state's claim warrant system could not make payments soon enough to enable the division to properly serve claimants. In November, 1973,

medical payments and annual dividend payments were placed on the state's claim warrant system, leaving only disability compensation payments being made manually by the division. Officials of the State Management Systems Bureau advised us that at the present time, only four state agencies issue checks or warrants outside the state claim warrant system. Besides the division, these agencies are the units of the University System, the Employment Security Division, and the Department of Social and Rehabilitation Services. Programs are presently being designed to bring the Employment Security Division and the Department of Social and Rehabilitation Services into the state claim warrant system.

Presently clerks at the division manually prepare warrants each day. The number of warrants prepared manually ranges from 600 to 1,000 every two weeks. A claims examiner first authorizes the payment by filling out a "face sheet" which is given to a clerk who types the warrant. Another clerk processes checks through a check protector machine which includes a facsimile signature, and a third clerk prepares the checks for mailing. Carbon copies of each warrant are used to update the division's computer files. A summary form is also prepared and becomes the input to the Statewide Budgeting and Accounting System.

Our review of this disbursement recording process revealed some weaknesses in internal control. An effective means of attaining internal control and automating warrant preparation lies in using the state claim warrant system to make the disbursements. This would involve a separation of duties, as the division would initiate the warrant but would no longer be involved in the preparation, mailing, or reconciling of the warrants, which would be done by other agencies. The chance of human error in computing amounts and typing warrants would be reduced, and the division personnel would be relieved of the task of manually preparing the warrants.

As mentioned previously, the primary objection to placing compensation payments on the state claim warrant system was that payments were required by law (Section 92-714, R.C.M. 1947) to be paid at the end of each two-week period, and it was believed that the state claim warrant system could not make payment soon enough. This objection may have been valid at one time; however, improvements were made to achieve more prompt payments through the state claim warrant system, and this objection is no longer valid. More than one-half of the disability compensation payments involve a "fixed liability" where the same amount will be paid each two-week period, much as the silicosis payments that are now made on the state claim warrant system. There is virtually no reason why the "fixed liability" cases could not be put on the state claim warrant system and operated in much the same manner as the state's central payroll system which operates on a base data-exception system. Once the base data is entered, the system automatically produces the warrants upon certification until the base data is altered. In those instances where there is an immediate demand for payment, and where the state claim warrant system would not suffice, payment could be made through a contingent revolving account which is designed for such emergency purposes. These instances should be the exception.

We believe the circumstances which prompted our initial recommendation in 1970 and the recent recommendation by the Department of Administration have not changed. There are no valid reasons why a system could not be devised within the state claim warrant system to mechanically and routinely produce warrants for the payment of compensation.

RECOMMENDATION

We recommend that the division in consultation with the Department of Administration take the measures necessary to pay compensation benefits through the state claim/warrant system.

AGENCY ORGANIZATION

AGENCY ORGANIZATION

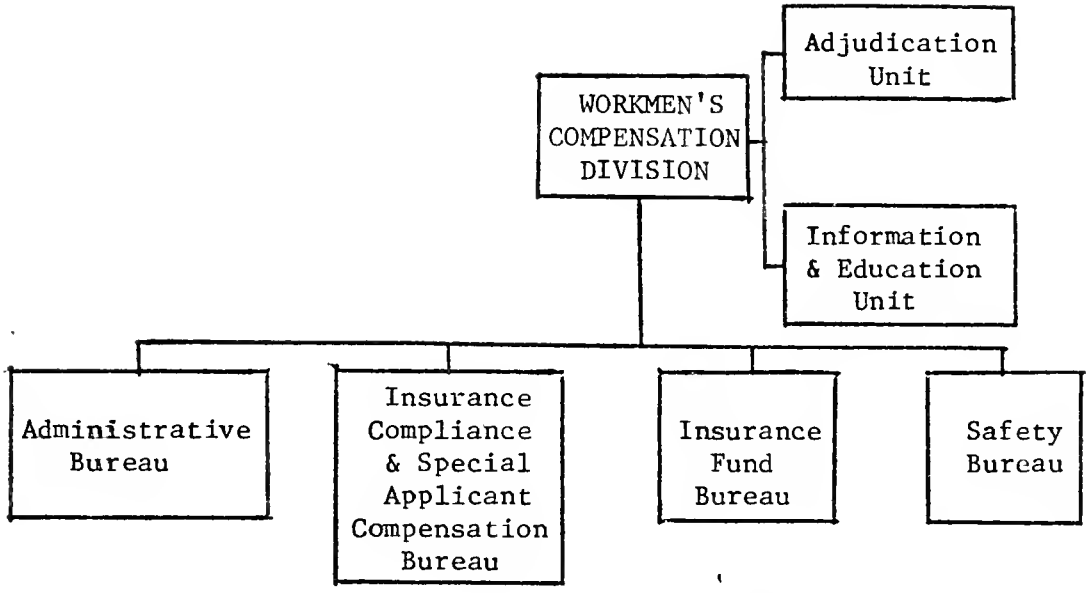
As previously mentioned, the present Workmen's Compensation Division was created in December, 1971, as a result of executive reorganization. Prior to executive reorganization, the division was known as the Industrial Accident Board, which consisted of three members. The board's primary duty was to insure that the Workmen's Compensation Act was properly administered and to oversee the operations of the state insurance program.

The board exercised policy-making and quasi-judicial powers. Actual administration of the Act and the state insurance program was accomplished by the chairman of the board, who was also the chief executive of the agency. Although some actions required approval of the board, this was a mere formality to ratify what had already been implemented.

The analysis made in conjunction with executive reorganization noted that board signatures were required on all orders. However, only one percent of the orders were ever disapproved by the board, and this was done only after the chairman recommended disapproval.

Executive reorganization, effective December 13, 1971, abolished the board and transferred all functions of the board to the Division with rights to the administrator to settle claims. The effect of reorganization was minimal. One signature instead of three is now required on administrative orders.

The present organizational structure of the division is presented at Exhibit E on page 148. Under the present organizational structure, the administrator exercises direct line control over the various bureaus and units of the division, as illustrated by the following diagram:



The abbreviated organization chart presented above depicts the fact that the administrator has direct line control over the administrative bureau, insurance compliance, and the safety bureau. These bureaus are the vehicle through which the administrator performs his primary function, i.e., satisfaction of the intent and enforcement of the workmen's compensation laws. The fourth bureau controlled by the administrator is identified above as the Insurance Fund Bureau. The insurance fund bureau is nothing more than a state-owned insurance program which classifies and underwrites risks, collects premiums, and pays benefits according to the requirements of law. These same activities are performed by insurance companies under Plan II.

Accordingly, the administrator presently has dual roles. He is (1) administrator of the state agency (the division) responsible for the prompt and fair administration and enforcement of the state workmen's compensation laws, and (2) the administrator and chief executive of the state insurance program, which in actuality is the largest single insurance company writing workmen's compensation insurance in the state. These two roles are not compatible and result in a conflict of interest.

The incompatibility and conflict of interest stem from the fact that the administrator in his dual roles is charged with enforcement of the laws over all insurers and operation of the state insurance program, which is in direct competition with private insurers. This conflict was assessed by the study performed by the U. S. Department of Labor (Insurance Arrangements Under Workmen's Compensation, Bulletin No. 317, 1969) which indicated that a conflict of interest exists when responsibility for operation of the state insurance program and responsibility for adjudicating injured worker appeals are combined, as is the case in Montana. According to the study, the conflict exists not only in the area of reviewing claims against the state insurance program, but also in regulations imposed upon the state insurance program and its competitors.

The U. S. Department of Labor study concluded that,

> ". . . protection of the worker's and the employer's interests suggests that the same agency should not administer the State compensation fund and hold hearings and pass on the decisions of the fund. Experience suggests that the fund is also more likely to be administered efficiently when it is an independent operation."

Of the 12 states that operate competitive state insurance programs similar to Montana, only Montana is subject to the conflict of interest inherent in reviewing and adjudicating workers' claims, regulating all insurers, and operating the state insurance program. The Compendium on Workmen's Compensation notes that "Only the Colorado and Montana funds, . . . are subject to the conflict of interest noted in connection with some funds." We found, however, that the Colorado State Fund and the administration are now organizationally separate. The Colorado State Fund manager informed us that the separation was made to eliminate any potential conflict of interest. Consequently, Montana is the only state with the conflict of interest circumstances.

Separation of the state insurance program from the administration of the division essentially means giving the state insurance program the rights and responsibilities of a private insurer. In the past, many cases were settled without the knowledge of the chief of the state insurance program bureau. The state insurance program has no right to appeal and cannot ask for a hearing with respect to a decision made by the administrator. Private insurers under Plans I and II, on the other hand, are free to appeal any administrative decisions they disagree with. The administrator acts in a regulatory capacity for private and self-insurers. It is the duty of the division to insure that medical bills and bi-weekly compensation payments are prompt and accurate. In addition, all settlements must be submitted to the administrator for his approval. All three plans pay a portion of their premiums to the division to meet administrative costs of running the division. The primary difference between an independent state insurance program and private carriers exists in the area of sales. The state insurance program is not required to solicit business, but rather provides an alternative to employers who do not desire or are unable to purchase private insurance or become self-insured.

An independent state insurance program provides a solution to the conflict of interest situation. In addition, it provides solutions for many of the problems presented throughout our report. As previously discussed, our review disclosed instances where state law may have been violated, documentation was lacking, and field representatives and the hearings procedure were not used to develop the facts surrounding some cases. These cases were settled by the former administrator, at times in contradiction to the information gathered by the state insurance program. Other cases were settled without the knowledge of the state insurance program under unusual circumstances.

In the case of an independent state insurance fund, the state insurance fund would have been able to routinely settle claims with the approval of the administrator, but the reverse would not be true. The administrator would not have been able to settle claims without the knowledge and approval of the state insurance fund. An independent state insurance fund, concerned with providing coverage at reasonable costs through efficient claim service, would have been obliged to challenge the administrator and request further negotiations or a hearing. This is not the case in Montana.

The state insurance program is an insurance operation and, as such, should stress its function as an insurer, while the division is a regulatory agency and, as such, should insure compliance with law under all three plans. The objectives of each boil down to the fact that the state insurance program should be concerned with operations and payment of claims from a sound insurance viewpoint in contrast to the division, which should be concerned with enforcement of the laws and fair treatment of employees and employers.

At the present time, up to one-half of the administrator's time is devoted to administering the state insurance program. This is not unusual, since the administrator is charged by law with responsibility for administration of the state insurance program. Because of the time devoted toward the state insurance program, the administrator's primary responsibility of insuring compliance under all three plans has suffered in the following areas:

A. Coverage under workmen's compensation, with selected exceptions, is mandatory. Section 92-207.1, R.C.M. 1947, states that the laws apply to all public employment and to all private employment not expressly exempted by law. The division has no effective system to insure coverage as required by law. As discussed earlier in our report, an estimated 2,600 firms do not have coverage. The suffering and hardship endured by injured workers

whose employers fail to carry workmen's compensation coverage should be one of the primary concerns of the administrator in a regulatory capacity.

B. All injuries are not reported to the division, nor does the division have any effective means of insuring that they are reported. As we noted earlier in our report, prompt and accurate injury reports are important in insuring the timely delivery of benefits to injured workers, as well as in rate-making and statistical reporting. Failure to report injuries deprives injured workers of their right to benefits provided by law. This should also be a primary concern of the administrator from a regulatory standpoint.

C. Compliance in many areas under the state insurance program is notably weak. We noted cases where payments were not promptly made, where medical bills were not promptly paid, and procedures to insure coverage of agricultural workers are months behind the schedule required by law.

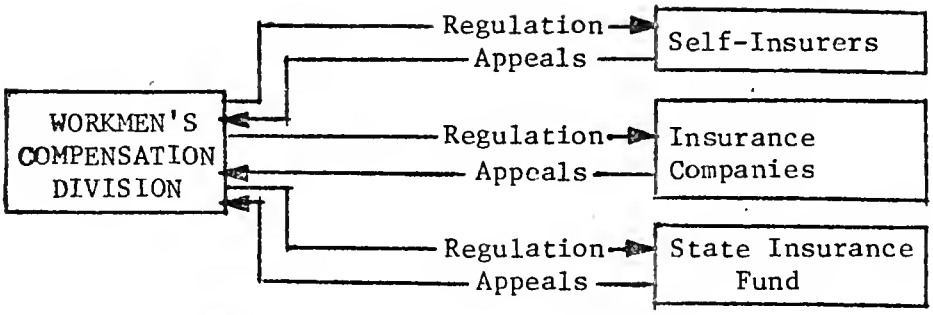
Most of the problems discussed throughout this report, including the possible penal violations currently under investigation, may have been averted had there been a separation between the state insurance program and the division's other functions. The administrator simply would not have had the exclusive control over the state insurance program that he had and presently has, and the state insurance program would have been separately identifiable and more equivalent and comparable to private insurers.

Being responsible for overall administration of the workmen's compensation laws, the main thrust of the division's effort should be to satisfy

the intent of these laws, namely, to insure coverage, to prevent industrial accidents, to adequately compensate injured employees, and promote the rehabilitation of injured employees. In contrast, the insurance function of the state insurance program should stress the insurance aspects of the laws, namely, providing coverage at reasonable rates, efficient servicing of claims, safety engineering, adequacy of reserves, and payment of claims.

The present organization of the division should be changed. The operation and control of the state insurance program should be organizationally and statutorily divorced from the division. The state insurance program could operate as a separate division within the Department of Labor and Industry. It should be no different in its relationship to the division than Plan I employers and Plan II insurers. It should be regulated at arm's length by the division in the same manner as private insurers are regulated.

The division should remain a separate entity within the Department of Labor and Industry. The division should remain attached to the department for administrative purposes only. The administrator of the division would still be appointed by the Governor and confirmed by the Senate. This would preserve the independence and separation of each function. The division is and should be organizationally and statutorily responsible for the administration and enforcement of the workmen's compensation laws. Enforcement and administration would be the same for self-insurers, private insurance companies, and the state insurance program. The division's activities should be in the area of administration, enforcement and compliance, safety, and hearings and adjudication. In the area of adjudication, the division should serve as a receptacle for appeals of decisions made by self-insurers, insurance companies, and the state insurance program. In summary, the division should operate as illustrated by the following diagram:



Separation of the state insurance program from the division would establish an effective appeals channel which does not now exist. This channel would serve to keep as many decisions as possible out of the realm of formal adversary proceedings. Decisions made by the state insurance program, or any other insurer for that matter, could be appealed to the division which would have no interest except resolving the matter in a fair and equitable manner within the parameters of law. The division should be able to summarily alter or uphold the decision being appealed strictly on the basis of its merits in terms of the law. In the event that any party disagrees with the summary judgment of the division, a formal hearing should be conducted by the division in the manner that hearings are now conducted, and a ruling made. Parties disagreeing with the ruling would have recourse to the courts.

Modification of the present organization in the foregoing manner would solve many of the problems and provide additional benefits.

RECOMMENDATION

We recommend that legislation be enacted to:

1. *Organizationally separate the state insurance program from the present Workmen's Compensation Division and establish it as a separate entity within the Department of Labor and Industry.*

2. *Vest the remaining organizational units of the workmen's Compensation Division with the power, authority, and responsibility to administer and enforce the workmen's compensation laws in the areas of coverage, compliance, safety, and adjudication of appeals.*

FINAL COMMENTS

We have reviewed the comments and recommendations contained in this report with the administrator of the Workmen's Compensation Division and his chief assistants. They have advised us that action to improve operations has been taken in many of the areas discussed in the report.

Pertinent sections of the report have also been discussed with the directors of the State Department of Administration and Labor and Industry, as well as officials of the Montana Medical Association, its affiliate, the Montana Foundation for Medical Care, and the Montana Bar Association. We invited the written comments of each of the foregoing officials. The written comments provided by these officials are included at the back of the report. In those instances where the officials raised issues warranting clarification, we have inserted appropriate comments.

We wish to express our appreciation to the administrator and his staff as well as the representatives of other organizations for their cooperation and assistance.

Respectfully submitted,

Morris L. Brusett

Morris L. Brusett
Legislative Auditor

June 14, 1974

EXHIBIT A

WORKMEN'S COMPENSATION DIVISION
MONTANA COMPLIANCE WITH RECOMMENDATIONS MADE BY NATIONAL COMMISSION ON STATE WORKMEN'S COMPENSATION LAWS

Prior to and Subsequent to July 1, 1973

As of January, 1974

NATIONAL COMMISSION RECOMMENDATIONS	MONTANA COMPLIANCE Prior to 7/1/73	MONTANA COMPLIANCE After 7/1/73
1. Coverage by workmen's compensation laws be compulsory and that no waivers be permitted.	No	Yes
2. Employers not be exempted from workmen's compensation coverage because of the number of their employees.	Yes	Yes
3. A two-stage approach to the coverage of farmworkers. First, as of July 1, 1973, each agriculture employer who has an annual payroll that in total exceeds $1,000 be required to provide workmen's compensation coverage to all of his employees. As a second stage, as of July 1, 1975, farmworkers be covered on the same basis as all other employees.	No	Yes
4. As of July 1, 1975, household workers and all casual workers be covered under workmen's compensation at least to the extent they are covered by social security.	No	No
5. Workmen's compensation coverage be mandatory for all government employees.	Yes	Yes
6. There be no exemptions for any class of employees, suoh as professional athletes or employees of charitable organizations.	No	Yes
7. An employee or his survivor be given the choice of filing a workmen's compensation claim in the state where the injury or death occurred, or where the employment was principally localized, or where the employee was hired.	No	No
8. All states provide full coverage for work-related diseases.	Yes	Yes
9. Subject to the state's maximum weekly benefit, temporary total disability be at least 66-2/3 percent of the worker's gross weekly wage.	No	Yes
10. As of July 1, 1973, the maximum weekly benefit for temporary total disability be at least 66-2/3 percent of the state's average weekly wage, and that as of July 1, 1975, the maximum be at least 100 percent of the state's average weekly wage.	No	Yes

NATIONAL COMMISSION RECOMMENDATIONS	MONTANA COMPLIANCE Prior to 7/1/73	MONTANA COMPLIANCE After 7/1/73
11. The definition of permanent total disability used in most states be retained. However, in those few states which permit the payment of permanent total benefits to workers who retain substantial earning capacity, the benefit proposals be applicable only to those cases which meet the test of permanent total disability used in most states.	Yes	Yes
12. Subject to the state's maximum weekly benefit, permanent total disability benefits be at least 66-2/3 percent of the worker's gross weekly wage.	No	Yes
13. As of July 1, 1973, the maximum weekly benefit for permanent total disability be at least 66-2/3 percent of the state's average weekly wage, and that as of July 1, 1975, the maximum be at least 100 percent of the state's average weekly wage.	No	Yes
14. Total disability benefits be paid for the duration of the worker's disability, or for life, without any limitations as to the dollar amount or time.	No	Yes
15. Subject to the state's maximum weekly benefit, death benefits be at least 66-2/3 percent of the worker's gross wage weekly.	No	Yes
16. As of July 1, 1973, the maximum weekly death benefit be at least 66-2/3 percent of the state's average weekly wage, and that as of July 1, 1975, the maximum be at least 100 percent of the state's average weekly wage.	No	Yes
17. Death benefits be paid to a widow or widower for life or until remarriage, and in the event of remarriage two years' benefits be paid in a lump sum to the widow or widower. Benefits for a dependent child be continued at least until the child reaches 18, or beyond such age if actually dependent, or at least until age 25 if enrolled as a full-time student in any accredited educational institution.	No	No
18. There be no statutory limits of time or dollar amount for medical care or physical rehabilitation services for any work-related impairment.	No	No
19. The right to medical and physical rehabilitation benefits not terminate by the mere passage of time.	No	No

Source: U. S. Department of Labor, Division of Workmen's Compensation Standards, "State Workmen's Compensation Laws Compared With Essential Recommendations of the National Commission On State Workmen's Compensation Laws," September 30, 1973, and a review of recent laws enacted in Montana.

EXHIBIT B

WORKMEN'S COMPENSATION DIVISION

TYPE OF WORKMEN'S COMPENSATION PROGRAMS IN THE UNITED STATES

January, 1974

	Number of States
1. Type of Law	
Coverage Elective	16
Coverage Compulsory	34*
2. Self Insurance	
Permitted	46*
Not permitted	4
3. State Fund	
yes	16*
no	34
4. Private Employment Coverage	
Compulsory	29*
Elective	21
5. Public Employment Coverage	
Compulsory	43*
Voluntary	7
6. Coverage Exclusions (Private)	
Farm Labor	19
Domestics	25*
Casual	24*
7. Benifit Waiting Period	
3 days or less	15
3 to 7 days	35*
8. Retroactive Coverage	
None	1
7 days or less	8*
7 to 14 days	18
14 to 28 days	18
over 28 days	5
9. Attorney Fees	
Fixed, Established or Approved by Authorities	46
May be Established by Authorities	3*
No provision	1

* Denotes classification of Montana.
Source: U. S. Chamber of Commerce - Analysis of Workmen's Compensation Laws, 1973.

WORKMEN'S COMPENSATION DIVISION

COMPARATIVE FINANCIAL DATA ON OPERATIONS
January 1974

SUMMARY BY PROGRAM

	Fiscal Year Expenditures				
	1968-69	1969-70	1970-71	1971-72	1972-73
*Administration	$ -0-	$ -0-	$ -0-	$ 770,908	$ 868,752
State Fund	-0-	-0-	-0-	7,155,862	7,545,941
Silicosis	663,291	691,270	656,235	649,661	621,358
OSHA Safety	-0-	-0-	-0-	68,230	150,922
OSHA Statistics	-0-	-0-	-0-	18,790	34,280
OSHA Occupational Health	-0-	-0-	-0-	12,972	25,336
OSHA Mining	-0-	-0-	-0-	-0-	21,957
*Administration	6,507,865	7,276,973	7,517,084	-0-	-0-
Total Programs	$7,171,156	$7,968,243	$8,173,319	$8,676,423	$9,268,546

SUMMARY BY OBJECT

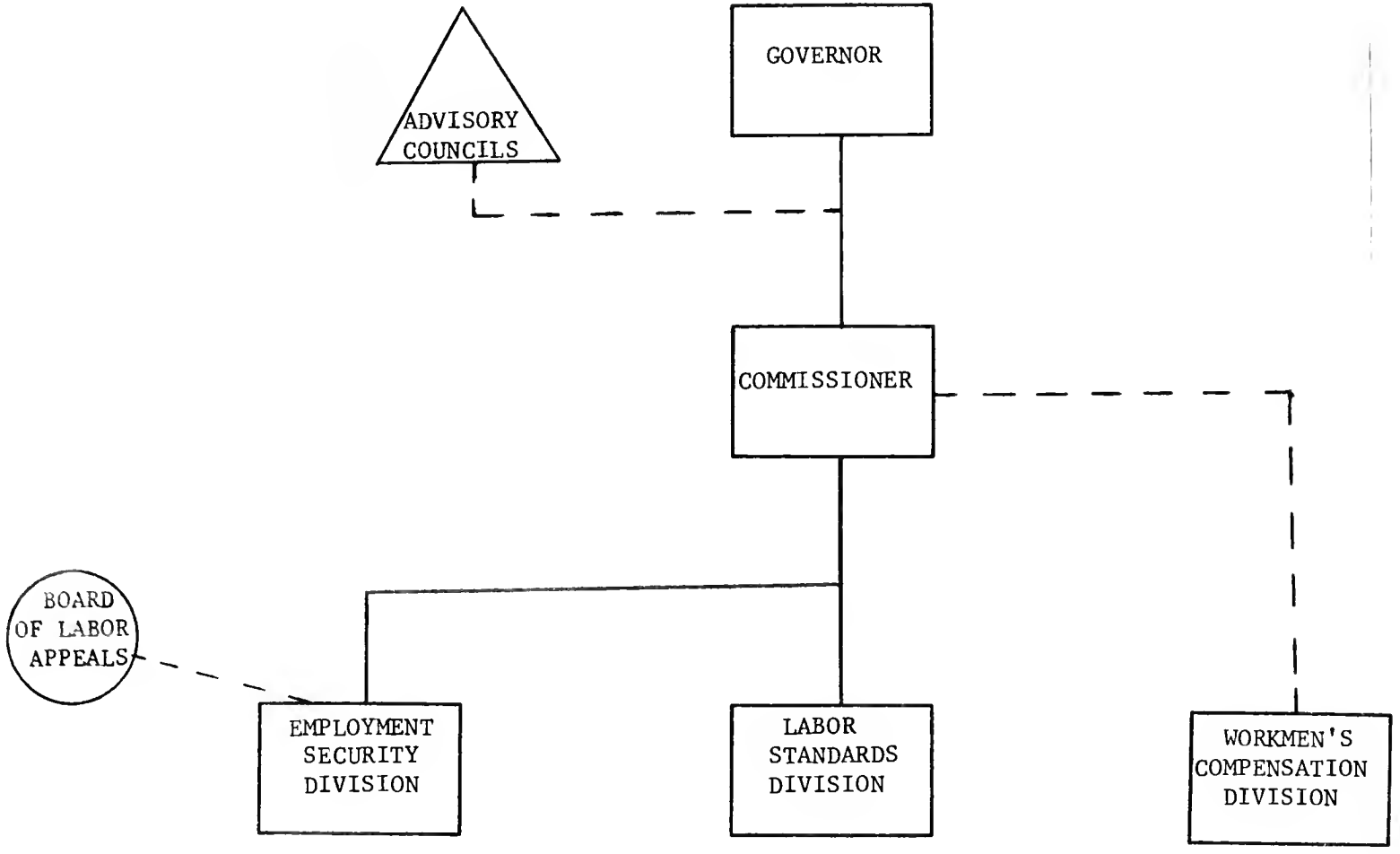
Personal Services	$ 404,153	$ 469,458	$ 488,753	$ 727,245	$ 872,608
Operations	225,219	331,719	350,759	742,461	948,662
Equipment & Livestock	20,602	28,131	28,816	32,863	48,137
Total Operating Costs	$ 649,974	$ 829,308	$ 868,328	$1,502,569	$1,869,407
Assistance, Grants & Benefits	6,521,182	7,138,935	7,304,991	7,173,854	7,399,139
Total Program	$7,171,156	$7,968,243	$8,173,319	$8,676,423	$9,268,546

SUMMARY BY FUNDING

General Fund	$ 663,291	$ 691,270	$ 656,235	$ 649,661	$ 621,358
Earmarked Revenue Fund:					
Administration Account	641,124	816,926	857,354	887,021	1,007,062
Loss Adjustment Account	-0-	-0-	-0-	506,011	661,761
Volunteer Firemen's Comp. Account	4,908	6,829	6,904	7,200	7,850
Federal & Private Rev. Fd.:					
Occupational Safety Acct.	-0-	-0-	-0-	68,085	150,922
OSHA Statistical Study Acct.	-0-	-0-	-0-	17,284	34,280
WCD Health Study	-0-	-0-	-0-	14,623	25,336
WCD Emergency Employment	-0-	-0-	-0-	3,153	-0-
OSHA Mining	-0-	-0-	-0-	-0-	21,957
Agency Fund:					
Industrial Ins. Liquid Acct.	4,062	56,600	3,000	-0-	-0-
Occupational Disease Acct.	2,848	2,016	2,232	557	1,053
Industrial Ins. Acct.	5,845,347	6,393,094	6,642,963	6,522,328	6,736,967
Second Injury Acct.	9,576	1,508	4,631	500	-0-
Total Funding	$7,171,156	$7,968,243	$8,173,319	$8,676,423	$9,268,546

Source: Unaudited data from Executive Budget and SBAS report, Form 641, dated 7/19/73.

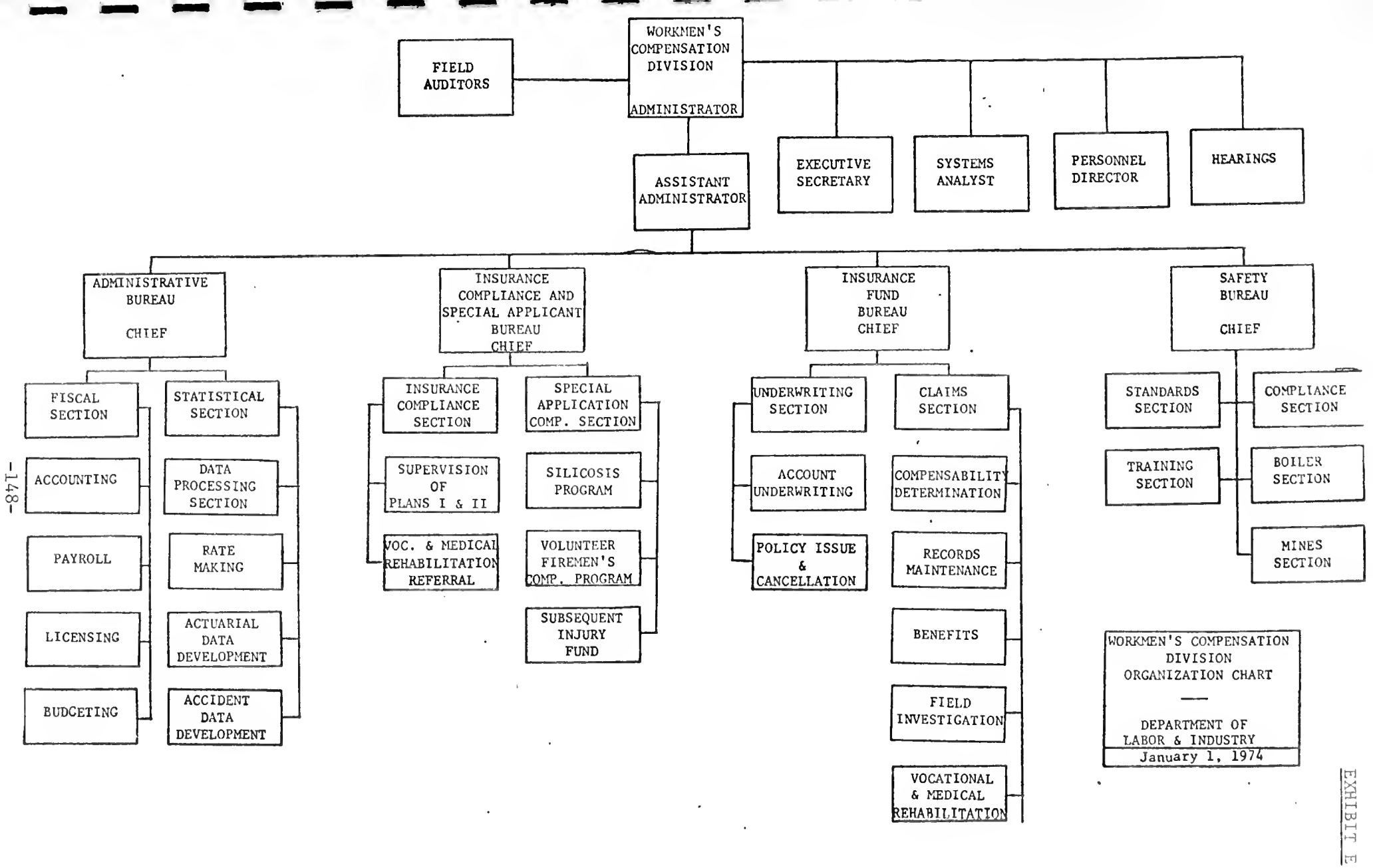
*Program structure was modified in 1971-72 resulting in allocation of expenditures previously classified as "administration."



Source: Executive Reorganization

DEPARTMENT OF LABOR & INDUSTRY ORGANIZATION CHART January 1, 1974

EXHIBIT D



WORKMEN'S COMPENSATION DIVISION
ORGANIZATION CHART

DEPARTMENT OF LABOR & INDUSTRY
January 1, 1974

EXHIBIT E

WORKMEN'S COMPENSATION DIVISION

RECAP OF CLAIMANT REPLIES TO LEGISLATIVE AUDITOR QUESTIONNAIRE

AUGUST 1973

	Number	Percent
Questionnaires Mailed	2,024	100%
Questionnaires returned undeliverable	243	12%
Questionnaires returned completed	838	41.4%
Questionnaires not returned	943	46.6%
TOTAL	2,024	100.0%
Questionnaires returned with usable response	824	40.7%

* * * * * *

1. Negotiated settlement with WCD	yes	543	66.0%
	no	280	34.0%
2. Experienced problems with WCD	yes	175	21.3%
	no	648	78.7%
3. Received weekly compensation payments	yes	518	63.3%
	no	300	36.7%
4. Received lump sum payments	yes	783	95.0%
	no	41	5.0%
5. Engaged an attorney	yes	393	47.7%
	no	431	52.3%
6. Attorney engaged before or after WCD contacted	before	111	29.2%
	after	269	70.8%
7. Requested or advised by someone to engage an attorney	yes	133	17.1%
	no	644	82.9%

Note: The number of "yes" and "no" answers for each question does not total 824 because come respondents did not answer all questions.

EXHIBIT G

WORKMEN'S COMPENSATION DIVISION

SUMMARY OF STATE REGULATION OF ATTORNEY FEES

STATES WHICH DO NOT REGULATE ATTORNEY FEES

1. Connecticut
2. Iowa
3. MONTANA
4. Nebraska
5. New Hampshire
6. Ohio
7. Pennsylvania
8. Washington

STATES WHICH REGULATE ATTORNEY FEES

Alabama . . . . . By law, the maximum fee is 15 percent of compensation awarded. The maximum is always fixed. Medical benifits are not counted in determining the fee. Payment is usually lump-sum.

Alaska. . . . . By law, there is a minimum fee of 15 percent on the first $1,000 or part: 10 percent on amount above $1,000. Board rarely fixes fee above the minimum. Medical Benefits are not counted in determining the fee. Payment is usually lump-sum.

Arizona . . . . . By law, the maximum fee is 25 percent of benefits awarded, subject to certain time limitations. Since no approval required at hearing level, the maximum is always charged. Medical benefits are not counted. Payment is usually in installments, with the attorney receiving 25 percent of each installment up to the maximum.

Arkansas . . . . . By law, the maximum fee is 30 percent on the first $1,000 or part; 20 percent on amount between $1,000 - $2,000; 10 percent on amount above $2,000. In contested cases the maximum is always approved. Medical benefits are counted in determining the fee. Payment is usually lump-sum.

California . . . . . By policy, the maximum fee is 10 percent of the amount recovered. Medical benefits are generally not counted Payment is usually lump-sum.

Colorado. . . . . Approval is on a case-by-case basis, but fee may not be based on the amount of the award; only on the amount of work involved. Medical benefits are not counted. The fee is usually paid as benefits accrue; not always in a lump-sum.

Delaware . . . . . By law, the maximum fee is 30 percent of the award or $2,500 whichever is smaller. The maximum is always approved. Medical benefits are not counted. Manner of payment is on a case-by-case basis.

District of Columbia. . . Approval is on a case-by-case basis. Medical benefits are generally not counted. Payment is usually lump-sum.

Florida . . . . . By policy, the maximum fee is 30 percent of amount recovered. Medical benefits are counted. Payment is always lump-sum.

Georgia . . . . . By policy, a fee of 1/3 of the award is approved in contested cases; 25 percent in settlements. Medical benefits are not counted. Manner of payment is on a case-by-case basis, but parties may apply for a lump-sum.

Hawaii . . . . . Approval is on a case-by-case basis. Medical benefits are not counted in determining the fee. Payment is always lump-sum.

Idaho . . . . . By policy, the board follows the fee schedule of the State bar association. If the case is settled prior to hearing a fee of 25 percent of recovery is approved; if settled on the day of hearing or an award by the board is made a fee of 33-1/3 percent is approved; if an offer is made prior to settlement, a fee of 33-1/3 percent on amount recovered exceeding the offer is approved; if an offer is made prior to an award, a fee of 33-1/3 percent of the amount exceeding the offer or 25 percent of the entire award, whichever is smaller, is approved. Medical benefits are not included in determining the fee. Manner of payment is on a case-by-case basis.

Illinois . . . . . By commission rule, there is maximum fee of 20 percent of the award, which is usually approved in contested cases Medical benefits, if disputed or included in a settlement are included in determining the fee. Payment is usually made in lump-sum, but determined on a case-by-case basis.

Indiana . . . . . Board rule provides a maximum fee of 20 percent on first $1,000 or part; 15 percent on amounts between $1,000 and $3,000; 10 percent on amounts above $3,000. The maximum is generally fixed. Medical benefits are not included in determining the fee. Manner of payment is on a case-by-case basis.

Kansas . . . . . By law, the maximum fee is 25 percent of compensation recovered by agreement, award or judgment. The maximum is always approved. Medical benefits are not included in determining the fee. Manner of payment is on a case-by-case basis.

Kentucky . . . . . By law, the maximum fee is 20 percent of the amount recovered. The maximum is always fixed. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

Louisiana . . . . . By law, the maximum fee is 20 percent on the first $5,000; 10 percent on amounts above $5,000. The maximum is always approved. Medical benefits are not included in determining the fee. Payment is usually made in a lump-sum.

Maryland . . . . . By policy, the maximum fee is 20 percent on the first $7,000; 15 percent on amounts between $7,000 and $25,000; 10 percent on amounts above $25,000. The maximum is generally approved. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

Massachusetts . . . . . By policy, the maximum fee is 20 percent of the award, but approval is on a case-by-case basis. Medical benefits are generally not included in determining the fee. Payments are always made in a lump-sum.

Michigan . . . . . By rule, the maximum fee is 30 percent of the award, which is always approved in contested cases. Medical benefits are included in determining the fee. Payment is usually made in a lump-sum.

Minnesota . . . . . By policy, the maximum fee is 25 percent of the award. The maximum is always approved in contested cases. Medical benefits are not included in determining the fee. Payment is usually in installments, the attorney receiving 25 percent of each payment.

Mississippi . . . . . By law, the maximum fee is 25 percent of the award. The maximum is always approved in contested cases. Payment is always made in a lump-sum.

Missouri . . . . . Approval of the fee is on a case-by-case basis, but generally no more than 25 percent of the award will be allowed. Medical benefits are not included in determining the fee. Manner of payment is on a case-by-case basis.

New Jersey . . . . . By law, the maximum fee is 20 percent of the judgement. If compensation is offered, tendered in good faith or paid prior to hearing, the fee will be allowed only that part of the judgement or award in excess of the amount offered, tendered or paid. If the amount of judgement (or excess beyond good faith offer) is less than $500, a fee of not more than $50 may be allowed. The maximum is rarely allowed; fee is usually 16-2/3 - 17-1/2 percent of the award. Medical benefits are generally not included in determining the fee. Payment is always made in lump-sum.

Source: Compendium on Workmen's Compensation, National Commission on State Workmen's Compensation Laws, 1973.

New Mexico . . . . . Where no court proceedings are required, the maximum fee is 10 percent of the whole amount recovered. There is no approval required in such cases so the maximum is always charged. Where proceedings are necessary, the fee is fixed on a case-by-case basis. Medical benefits are included in determining the fee. Payment is always made in a lump-sum.

New York . . . . . Fee is approved on a case-by-case basis, but in no case may fee be based on the amount of the award; only on services performed. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

North Carolina . . . . . Commission follows guidelines of State Bar Association: a minimum fee of 15 percent of recovery but not to exceed 25 percent of recovery. Approval is on a case-by-case basis. Medical benefits are generally not included in determining the fee. Payment is always made in a lump-sum.

North Dakota . . . . . By rule, the fee is $20 an hour; never based on the award The fee is paid by a State fund whether or not the claimant prevails. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum

Oklahoma . . . . . By rule, the maximum fee is 20 percent of the award in contested cases; quantum meruit in uncontested cases. The maximum is always approved. Medical benefits are not included in determining the fee. Manner of payment is determined on a case-by-case basis. If the award is in installments, the attorney receives every fifth check up to 20 percent of the total award.

Oregon . . . . . Board follows the fee schedule of the State Bar Association; maximum fee of 25 percent of the award or $1,500 whichever is less. The maximum is usually approved. Medical benefits are not included in determining the fee. Manner of payment is on a case-by-case basis.

Puerto Rico . . . . . By policy, the maximum fee is 15 percent of the award in contested cases; 5 percent of amount recovered by settleme but in no case may fee exceed $1,000. The maximum is usua fixed. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

Rhode Island . . . . . By policy, the maximum fee is 15 percent of the award. The maximum is usually approved. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

South Carolina . . . . . Fee is approved on a case-by-case basis, but 33-1/3 percen is usually allowed in contested cases. Medical benefits are not included in determining the fee. Payment is generally made in a lump-sum.

South Dakota . . . . . Department follows guidelines of State Bar Association: maximum fee not to exceed 33-1/3 percent of award on cases going to hearing, 25 percent of award if case does not go to hearing. Medical payments may be included in determining the fee. Payment is sometimes in a lump-sum.

Tennessee . . . . . By law, the maximum fee is 20 percent of the amount recovered. The maximum is always approved. Medical benefits are not included in determining the fee. Payment is always made in a lump-sum.

Texas . . . . . By law, the maximum fee is 25 percent of the total recovery. In contested cases the maximum is always approved. Medical benefits are included in determini the fee. Payment is generally made in a lump-sum.

Utah . . . . . By rule, the maximum fee is $25 an hour or 15 percent the award, whichever is less. A fee in excess of $150- $200 is rarely fixed by theCommission. Medical benefits not included in determining the fee. Payment is always made in a lump-sum.

Vermont . . . . . Approval is on a case-by-case basis; average fee allo is 15 percent of the award. Medical benefits are not included in determining the fee. Payment is usually in a lump-sum.

Virginia . . . . . Approval is on a case-by-case basis. Medical benefits are not included in determining the fee. Payment is usually made in a lump-sum.

Maine . . . . . The employer is assessed the fees of the employees attorney, if in the Commissioner's judgement the services of the attorney were necessary to prepare expeditious desposition of the case.

Massachusetts . . . . . In any proceeding brought by the insurer to discontinue compensation, wherein the insurer is ordered to cont payments, the employee is awarded reasonable attorney fees.

Nebraska . . . . . Whenever an employer refuses payment or neglects to pay compensation for 30 days after injury, and proceeding are held, the employee shall be allowed a reasonable attorney's fee.

New Jersey . . . . . It is within the discretion of the Hearing Officer to a party in whose favor judgement is entered a reasona attorney's fee.

New Mexico . . . . . (a) Where the court is called upon to approve a settlemen and the employee is not represented by counsel, the court may appoint counsel and fix his fee to be taxed as costs against the employer. (b) If the employee is represe by counsel, his fee is taxed as costs against the em (c) Where the claimant collects compensation through proceeding, the fee of his attorney is paid by the employ in addition to compensation.

Oregon . . . . . If a direct responsibility employer or the State compensa department refuses to pay compensation due under an or or otherwise unreasonably resists the payment of comp sensation, the employer or department shall pay a reas attorney's fee.

Rhode Island . . . . . Counsel fees are awarded to employees who successfully prosecute petitions for compensation, for medical expense and to amend preliminary agreements.

Vermont . . . . . The Commissioner may allow the claimant to recover rea able attorney fees when he prevails.

Source: Compendium on Workmen's Compensation, National Commission on State Workmen's Compensation Laws, 1973.

EXHIBIT H

REPORT

ON

THE WORKMEN'S COMPENSATION DIVISION

OF

THE STATE OF MONTANA

January 4, 1974

HENDRICKSON AND BIRD
Actuarial and Pension Services

HENDRICKSON AND BIRD

Actuarial and Pension Services

Alton P. Hendrickson,
Associate of the Society of Actuaries
Philip A. Bird, Jr.,
Chartered Life Underwriter

600 Park Avenue
Helena, Montana 59601
(406) 442-5141

January 4, 1974

Mr. Morris L. Brusett
Legislative Auditor
Capitol Building
Helena, Montana 59601

Dear Mr. Brusett:

Pursuant to your request, I have enclosed my report on the Workmen's Compensation Division of the Sate of Montana. The comments and recommendations stated herein were based on information obtained from the office of the Legislative Auditor, as well as from other sources, as deemed necessary.

Sincerely,

Alton P. Hendrickson, ASA

APH/ jw
Enc.

INTRODUCTION

Workmen's compensation insurance is available to Montana employers through one of three plans:

Plan I	Self-insurance
Plan II	Private carriers (insurance companies)
Plan III	Workmen's Compensation Division's state fund

Plan I can only be selected by employers large enough to absorb the contingency risk. Plans II and III are available to all employers. The benefits and rate filings are prescribed by legislation applicable to compensation insurance in Montana. Under guidelines established by the National Commission on State Compensation Insurance, the benefits were amended as of July 1, 1973.

While the state fund is permitted to promulgate its own rates, private carriers offering compensation insurance must use the rates established by the National Council on Compensation Insurance with appropriate adjustments for volume discounts, experience ratings, dividends and uniform modifications at the carriers' discretion. The NCCI is a statistics compilation and rate making bureau with regional offices serving the United States and was established by the National Association of Insurance Commissioners to provide these services to the various states. Montana is a member of the NCCI and is serviced by the Northwestern Compensation Rating Bureau of Portland, Oregon.

A review has been conducted into the rate making procedures of the Workmen's Compensation Division of the State of Montana and the actuarial services provided to it. The review was based upon information and data maintained by the Workmen's Compensation Division, telephone conferences with members of the National Council on Compensation Insurance, the Northwestern Compensation Rating Bureau and the laws of Montana applicable to compensation insurance. A summary of our findings and recommendations are contained in this report as requested by the Legislative Auditor.

REVIEW OF CURRENT PROCEDURES

As permitted by law, the Workmen's Compensation Division promulgates its own rates which are adjusted annually based on the actual experience in each employer classification. An actuarial consulting firm is retained to develop these manual rates. Experience refunds are given to employers at the end of each fiscal year provided certain requirements are met and, in particular, that the incurred premiums exceed the amount reserved for incurred losses. The experience refund, which is a form of dividend, is determined by the Workmen's Compensation Division.

In comparison to the National Council on Compensation Insurance manual rates used by private carriers, the state's manual rates are lower in approximately two-thirds of the classifications and higher in the remaining one-third. However, this statistic is not necessarily a true indication of the actual rate differences since private carriers offer a modified rate to certain employers based on actual experience in the preceding three years. The differences in the manual rates arise mainly as a result of the statistics used to determine the net rates before they are adjusted for expenses. The NCCI uses statistics based on all employees covered by workmen's compensation insurance in Montana while the state's rates are based on only the statistics of the employees covered by its fund. Because the state's rates are based on the experience of a smaller number of lives, its rates would tend to fluctuate more from year to year. Another factor causing differences in the rates could be the adjustments used to develop the manual rates from net rates. After net rates are calculated from statistics, they must be increased to cover administive expenses, acquisition costs, taxes, profits, etc. While the adjustment techniques for the NCCI and the state were not available, we would assume the techniques to differ since the state's rates need not be increased for acquisition costs and profits.

In determining its liabilities, the Workmen's Compensation Division annually establishes reserves in each of several categories. These reserves are developed internally and evaluated periodically for adequacy by an actuarial consulting firm.

As a member of the National Council on Compensation Insurance, the Workmen's Compensation Division is also required to maintain records which are submitted to the statistical division of the NCCI in New York. These statistics together with those supplied by private carriers are compiled to develop NCCI's Montana rates used by private carriers.

RECOMMENDATIONS

(1) We recommend that the Workmen's Compensation Division consistently use the insurance rates developed annually by the NCCI, subject to the approval of the Insurance Commissioner. Because of savings in acquisition costs, taxes, and possible administrative efficiency, it might be will to reduce all state rates by a uniform percentage, such as 20%. As in the past, individual employer refunds would be made at the end of each year of favorable experience.

This recommendation is made for several reasons:

(a) Because of its vast experience and facilities as well as its access to a larger volume of accurate statistics, the NCCI is better equipped to produce meaningful rates than a private organization.

(b) The rates would be in direct proportion to those used by private carriers and would not have the random inconsistencies which now occur. As a result, the rates should be more palatable to everyone, particularly the employers.

(c) The rates are already being produced by the NCCI for Montana and thus no additional expenses would be incurred. The charges currently being incurred for the production of the state fund's rate would be eliminated.

(d) Of each $1.00 of premium determined by the NCCI, approximately 60 cents is needed to pay claims and 40 cents is for expenses. Of the 40 cents, 17.5 cents is for acquisition costs and 2.5 cents is for profits. These two expenses are a necessary operational cost of private carriers, but not of the Workmen's Compensation Division. It is on this basis that the uniform reduction of 20% is suggested. If the premium is not reduced, an adjustment should be made at the end of the year through a larger dividend. The advantage of a reduced premium is that the employer will not be required to invest as much working capital during the year only to have it refunded at the end of the Year.

(e) The NCCI rates have generally been accepted by other states offering compensation insurance in competition with private carriers. The NCCI office in New York is only aware of two of the twelve states which do not base their rates on the NCCI rates, Maryland and Montana.

Four of the ten states using the NCCI rates reduce their rates by a flat percentage; Colorado, New York, Oregon, and Utah.

(2) As noted earlier, private carriers are offering experience rates to qualifying employers. These rates can be higher or lower than the manual rates, depending upon the past experience of the employer. We recommend that the Workmen's Compensation Division offer its employers similar experience rates as established by the NCCI. This approach would:

(a) Encourage safety in industry by recognizing favorable past experience in the form of premium discount at the deginning of each year.

(b) Equitably penalize poor past experience on an individual basis rather than on a classification basis. Overcharges, in the event of improved experience, would be adjusted through dividends at the end of each year.

(c) No additional expenses would be incurred by the Workmen's Compensation Division since experience rating is included in the services provided by the NCCI.

(3) Certain fixed costs are incurred for record-keeping and administrative costs by the Workmen's Compensation Division on all employers covered, whatever their size. Therefore the actual cost per premium dollar decreases as the size of the premium increases. We recommend that the state incorporate a schedule for reducing the charges to employers whose annual premiums exceed specific minimums. The reductions would vary with size of the premiums. Private carriers as well as most state funds offer such reductions to their clients.

(4) Because the state fund covers more individuals than any private carrier in Montana, it has the most meaningful experience to offer the NCCI in its rate making procedure. It is therefore essential that every effort be made to provide the NCCI with complete and accurate statistics. While it is recognized that the Workmen's Compensation Division has cooperated with the NCCI in providing requested records, it is our understanding that improved record-keeping techniques could provide more meaningful statistics. We therefore recommend that the NCCI be requested to assist the Workmen's Compensation Division in reviewing its record-keeping system and in designing new procedures, where feasible, to obtain the best possible statistics.

(5) Reinsurance is the process whereby an insurer transfers a portion of its own risk to another insurer; this is particularly advantageous in the event of catastrophic losses. The Workmen's Compensation Division has been covered by reinsurance since 1969 in addition to maintaining a catastrophe reserve of $750,000. We have not determined if the present reinsurance program provides adequate coverage or if, in fact, it provides more coverage than is practical. We recommend that a complete investigation be conducted into the adequacy of both the reinsurance program and the catastrophe reserve. Such investigation should include a report on the past experience of the coverage, including premiums paid and payments received. Guidelines should also be established for the amount of risk the state should retain and self-insure.

(6) We recommend that the Workmen's Compensation Division retain and independent actuarial consulting firm to provide an actuarial valuation report on the state's fund annually. An actuarial firm is presently retained to develop rates and review reserves, but an actuarial valuation is not provided.

The purposes of the actuarial valuation would be; (1) to provide a summary of the assets and liabilities of the fund, (2) establish necessary reserves, (3) determine the current years' gain or loss, and (4) provide an objective analysis of the financial condition of the fund. None of these subjects are currently included in the annual actuarial report submitted to the Workmen's Compensation Division.

COMMENTS

It is our opinion that the implementation of the recommendations in this report would be advantageous to the operation of the Workmen's Compensation Division of the State of Montana for several reasons:

(1) The rates would be more consistent with those used by other insurers and would more clearly define any competitive edge over private carriers.

(2) Being based on a larger volume of statistics, the rates would have less chance of random fluctuation and should more accurately represent the experience of Montana employers.

(3) The Workmen's Compensation Division would be relieved of its responsibility for promulgating rates and the expenses incurred.

(4) A periodic actuarial valuation would better reflect the fund's financial position, as well as offering guidelines for future changes and improvements.

There were no indications in the documents provided by the office of the Legislative Auditor which would represent or signify financial weaknesses in the insurance funds administered by the Workmen's Compensation Division of the State of Montana. Because of the lack of documentation as to the basis for reserves, we are unable to offer an independent judgement as ot the financial strengths or weaknessess of the insurance fund. We can offer reference to page 9 of the Actuarial Review Concerning Manual Rates Effective July 1, 1973 which states the opinion of G. Frank Waites of Coates, Herfurth & England, an actuarial consulting firm, that the fund can be maintained on a sound financial and actuarial basis by adjusting rates each year to conform to changing experience and benefits.

While it can be maintained on a sound financial and actuarial basis by adjusting rates each year, it is our opinion that the truest indication of whether such is, in fact, the case can best be determined through an annual actuarial valuation. Such a valuation should be conducted externally by a qualified independent actuarial firm. The valuation should be complete, with particular emphasis on experience gains and losses, including an analysis as to the reasons for them. An actuarial valuation was not within the scope of this report, nor the annual report submitted by Coates, Herfurth & England.

Service to clients is a vital function of carriers of compensation insurance. Because a review of the services provided by the Workmen's Compensation Division was not within the scope of this report, no comments or recommendations have been made on this subject.

AGENCY REPLIES

STATE OF MONTANA
DEPARTMENT OF LABOR AND INDUSTRY
WORKMEN'S COMPENSATION DIVISION
815 FRONT STREET
HELENA, MONTANA 59601
THOMAS L. JUDGE, GOVERNOR

LAWRENCE M. ZANTO
[redacted]N
ADMINISTRATOR

June 10, 1974

The Honorable Harold E. Gerke, Chairman
Joint Legislative Audit Committee
State Capitol Building
Helena, Montana 59601

Dear Representative Gerke:

Enclosed are the responses of the Division of Workmen's Compensation to the various recommendations made by the Legislative Audit Office relative to the operations of the Division.

We appreciate the opportunity to review the audit findings and have our comments included with the published report. You will note that we have agreed with a majority of the recommendations or offered viable alternatives. In those instances where we have disagreed, we have briefly indicated the reasons for our disagreement. After a more detailed study of the final recommendations, we will be happy to offer a more indepth explanation at your convenience.

We sincerely appreciate the efforts of the Legislative Auditor and his staff and compliment them on the professionalism they displayed in the conduct of this audit.

Please advise us if we can be of any further assistance.

Sincerely,

Lawrence M. Zanto
ADMINISTRATOR

LMZ/jem
Enclosures

INSURANCE COVERAGE

ENROLLMENT OF EMPLOYERS

Recommendation - Page 22

1. *Consult with the Employment Security Division to devise a mechanical means of preparing an exception list of employers registered with one agency but not the other.*

We agree with this recommendation and have initiated contact with the Employment Security Division (ESD). We are in the process of designing a new data processing system which will better fill the needs of the Division. This system will consider including a common number that can be used to cross reference the ESD and Division files.

We do question the validity of the auditors' projections on Page 17. We understand that the universe (18,000 employers) used by the auditors includes all employers registered with ESD. Since all employers registered with ESD do not require workmen's compensation coverage, they should be excluded from the universe before projecting the number of employers requiring coverage. The auditors, however, have apparently identified some employers registered with ESD who do not have coverage. We would appreciate receiving a list of these employers so that we can follow up on this to assure that the necessary coverage is obtained.

We understand that the comparison of ESD and Division employers was made in the month of October 1973, three months after compulsory coverage went into effect. It is not surprising and hardly critical that the auditors were able to identify some firms that were not covered.

The Division has labored under difficult circumstances all year just trying to enroll employers seeking coverage. From July 1, 1973 to April 1, 1974, the number of employers enrolled under Plan III increased from 8,573 to 15,626. The staff has put in many extra hours and weekends attempting to process and enroll all the new employers. Although we were unable to thoroughly research the 16 firms identified in the auditors' sample as not being covered, we did find that at least three were enrolled within a few

months after the auditors' October review. In addition, we found one firm that apparently does not even require coverage since it has no employees and is a sole proprietorship in a professional occupation. This tends to invalidate the auditors' projections.

AUDITOR'S COMMENTS

Our projection of uninsured employers is absolutely sound. The 18,000 employers registered with ESD is a rounded figure used for report purposes. As of November 1, 1973, there were actually 18,291 active employers registered with ESD. ESD and the division basically exempt the same employers from coverage except for two categories, agricultural employers and casual employers. In the first instance, i.e., agricultural employers, coverage is required by the division but not by ESD. Consequently, agricultural employers are not included in the projection. In the second instance, casual employers with payroll in excess of $500 per year are required to have coverage by ESD but not the division. ESD advised us that active employers in this category are less than 100 in number. Since we cite the figure of 18,000 and use statistical sampling procedures which result in a range projection as presented in the report, 100 employers or less has very little effect on the projection which indicates, irrespective of specific numbers, that a substantial number of employers are not insured as required by law.

The law on compulsory coverage was enacted March 29, 1973, and our sample was selected from employers on record as of November 1, 1973. This gave the Division seven months to (1) obtain a listing of all employers from ESD, (2) extract those employer names not covered by Plan II or Plan III, (3) notify the new employers of the compulsory coverage requirements, and (4) receive applications from the new employers.

Notwithstanding this, a substantial number of employers were found not to have coverage and, in fact, one of the uninsured employers disclosed by our sample, which the division was unaware of, is within one city block of the division premises in Helena.

Finally, it is difficult to envision how the division, after having seven months to identify and enroll employers under a compulsory law, can simply dismiss the significance of 14.2 percent by saying that it is not "surprising nor critical" that "some" employers were not covered.

The one firm referred to by the division as sole proprietorship is in fact a professional corporation, having two corporate officers. Section 92-208, R.C.M. 1947, states that officers of corporations may elect not to be bound as employees under the Act by a written notice in the form provided by the Division. This election not to be bound was not and has not been made by the corporation.

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Recommendation - Page 22

2. *Establish routine procedures for the follow-up and enrollment of employers identified by:*

   (a) Comparison to Employment Security Division records.

   (b) Safety Bureau inspections.

   (c) Cancellation due to delinquent premiums.

   (d) Research of medical claims.

Although the Division has followed up to determine whether employers were enrolled, we agree that routine procedures should be established. We intend to prepare written procedures for follow-up and document the actions taken.

The information contained in the auditors' report on Pages 18 and 19 concerning the follow-up on employers identified by the safety inspections conflicts with the information available in our records. We were able to identify 23 of the 29 employers reported by Safety as not having coverage during July 1973 to December 1973. Applications were sent to six of these employers and although the auditors' report indicates that the remaining firms were not contacted, the Division did follow up and determine that in seven cases no coverage was necessary and in five cases the firms were covered under Plan II or III. In the case of the post and lumber firm mentioned in the report,

the matter has been turned over to the Division's legal counsel.

In summary, the recommendations suggest the establishment of procedures to follow up on employers who are identified through the routine and normal course of the Division's operations. As previously stated, we agree with this concept. However, the auditors imply that the Division should seek out employers who have no coverage. If the auditors believe this to be the direction the Division should take, this requires an increase in personnel and resources. Seeking out employers who have no coverage expands the acitivities of the Division beyond what is contemplated in the recommendations. We are not necessarily opposed to such a role but it must be pointed out that such an activity would require increased funding.

APPLICATION OF PENALTIES

Recommendations - Page 25 and 26

1. *Seek application of the penalties required by Section 92-207, R.C.M. 1947, against all employers who refuse to obtain workmen's compensation insurance.*

2. *Seek the legislation necessary to:*

   (a) Repeal the provisions of Section 92-211, R.C.M. 1947.

   (b) Establish a special compensation fund for payments to uninsured employees to be funded by assessments to all three plans.

   (c) Allow injured employees of uninsured employers the option of suit against their employer or compensation from the special compensation fund.

   (d) Allow the division to pay medical and disability compensation at the option of the injured employee in exchange for the right to subrogation of the employee's interests.

   (e) Allow the division to undertake actions against uninsured employers to recover the costs of the compensation paid to the injured employees.

The Division agrees that willful violations of the compliance requirements in the law should result in a request to county attorneys that charges be brought in such instances.

The recently revised Workmen's Compensation Act now covers most employers and employees as indicated by the legislative auditors. It has been a monumental task to attempt to bring all employers in compliance. The Division has carried on a public awareness campaign in order to explain the new changes in the Act and compliance requirements. This has included press publicity and discussions with various employer groups throughout the state. The legal counsel for the Division sends letters to employers who may be required to carry workmen's compensation insurance. Thus, the Division has in fact taken action on workmen's compensation compliance. The Division feels it is better to seek voluntary compliance and carry on an education program for employers during the adjustment period subsequent to the vast expansion of compulsory coverage. However, it is time that the Division request that charges be brought in cases of willful violations of the Act in the area of compliance, and the Division is formulating a program for such action.

The legislative auditors' suggestion that the Division seek legislation establishing a special fund for payments to uninsured employees is sound and such a law would certainly be in the best interests of injured workmen. The Division will thoroughly consider the proposal for possible legislative action.

RATES

Recommendation - Page 36

1. *Establish rate-making processes which:*

   a) *Respond more promptly to industry loss experience.*

   b) *Incorporate experience rating procedures, and*

   c) *Provide for volume discounts.*

It is difficult to respond to the first recommendation in that we do not know what particular steps or procedures the auditors have in mind to enable us to respond more promptly to industry loss experience. Rates are reviewed and established once a year and more frequent reviews would not be feasible.

Several factors affect the establishing of rates including industry loss experience. The actuary develops computer-prepared, proposed preliminary rates based on the last full three-year loss experience. Benefit changes as a result of legislative actions are incorporated by a loading factor. The preliminary proposed rates are further modified by applying credibility factors to classifications with limited experience. The actuary and members of our staff review the preliminary proposed rates for each classification. At this time, the three-year experience is again evaluated, NCCI rates are considered, and the most recent year's experience is reviewed. In addition, the actuary and our staff consider possible increases in medical, administrative and compensation costs, costs of reinsurance and vocational rehabilitation, and the levels of our reserves. The rates are then finally established. Although this is a brief explanation of the rate-making process, we do not believe it differs substantially from the NCCI method.

If, through this first recommendation, the auditors are referring to the two examples in the report on Page 30, it is important to note that even if NCCI rates were being used, it would not have significantly changed the results.

We agree with the two recommendations on experience rating and volume discounts and hope to incorporate these procedures in our rate-making process.

Recommendation - Page 36

2. *Examine the possibility of greater use of NCCI to establish more equitable and responsive rate-making processes for the state insurance program.*

We are certainly willing to examine the use of NCCI rates but several factors must be considered:

1. In certain class codes, NCCI rates may not result in the operation of a financially sound State Fund because the rates are too low based on our experience. This does not effect the insurance carriers because they do not have to accept the risk, yet the State Fund cannot refuse coverage to any employer.

2. In certain class codes, NCCI does not establish rates. Therefore, the Division would still have to establish some rates.

3. In other class codes, it would appear that employers would be paying more for coverage even considering a discount for profit and commissions in spite of the fact that our experience indicates that the rate should remain the same or be reduced.

Incorporating experience rating and volume discounts into our rate-making process will go a long way toward resolving any inequities in the system, and the use of NCCI rates may not be necessary or wise.

AUDITOR'S COMMENTS

The division overlooks the fact that (1) NCCI rates are customized to the employer, and where an employer's loss experience is high, the rates will be commensurate, and (2) the rates set by NCCI include the loss experience of Plan III (State Insurance Program) employers. With these two factors, the NCCI rates would include and be responsive to the experience of any employers whether high risk or low risk.

While the division's assertion that all the uninsurable, high-risk employers resort to the state insurance program for coverage may or may not be true, it is not evident in the gross insurance statistics maintained by the division. Our analysis showed that while the Plan III (State Insur-

ance Program) insures more employers than Plan II carriers, the number of accidents reported through Plan II has been higher than Plan III. In addition, the number of claims filed under both plans is quite similar. These statistics would seem to indicate that the indices of risk, namely, accidents and claims, are not higher in Plan III than Plan II.

Furthermore, even if there are employers who are uninsurable due to heavy loss experience, it would seem that the division, having statutory responsibility for safety, should promptly focus safety personnel on these employers to improve job safety and reduce losses. Consequently, extreme losses should be only a temporary situation.

Contrary to what the division says, the division would not have to establish these rates itself. NCCI would use information supplied by the division to establish rates in these classes. An NCCI official advised us that NCCI will do this if the need arises. According to the official, NCCI formulated special rates in Florida for fiberglass boat building and in Idaho for volunteer firemen and inmates at institutions as well as special rates for other states.

The statement made by the division does not consider the fact that NCCI rates incorporate experience rating and volume discounts. These rate modifications, in addition to dividends based on each employer's experience, would, in effect, customize the rates for each employer. Consequently, an employer would not pay a higher rate than is warranted by his individual experience.

PREMIUMS

Adjustment of Initial Deposits

Recommendations - Page 39

1. *Establish procedures whereby the levels of initial deposits are allowed to tolerate a uniform percentage of fluctuation in premiums before being adjusted.*

2. *Periodically review the adequacy of all initial deposits and require increased deposits or return excess deposits as the case dictates.*

3. *Follow schedule for initial deposits recommended by the National Council on Compensation Insurance.*

We agree with these recommendations in principle and will establish a uniform rate fluctuation percentage and provide for the adjustment of initial deposits. This will be considered for computer application in designing our data processing system. At this point, it appears that because of the erratic fluctuations in some industry payrolls, it would not be practical to adjust initial deposits. Our primary concern is logging and road construction firms. Their payrolls may significantly increase and decrease on a month-to-month basis. The Division is not aware of the fluctuations until after the fact, and we would be requesting and sending initial deposits continually. Further study of these types of industries is necessary and possibly such firms should supply a bond as opposed to a cash deposit.

We do follow the schedule recommended by NCCI. Implementation of the first two recommendations discussed above solves the problem discussed in the auditors' report. There are no specific steps to be taken to implement this recommendation.

Premium Due Notices

Recommendations - Page 40

1. *Use data processing services to print premium due notices.*

2. *Establish procedures to verify the absence of premium payments just before premium due notices are mailed.*

3. *Design follow-up procedures for premium reports not returned.*

We agree with the first recommendation and will incorporate this into our data processing program.

The second recommendation creates practical problems in that it requires searching for payments that are in but have not completed the cash receipt process. It may be more practical to include a notation on the premium due notice advising the employers to ignore the notice if they have recently submitted payment. This is a standard business practice.

With reference to the third recommendation, there is and has been for many years follow-up procedures for premium reports not returned. Data processing generates a list of employers who have not submitted payroll reports. Underwriting, using this list, sends a letter to the employer advising him that his enrollment will be cancelled because of "Failure to submit payroll reports and premiums . . ." The letter further states that if the employer submits the payroll and premium for the stated periods, the cancellation process will be terminated. This procedure has been in effect since at least 1969.

Aging of Premiums Due

Recommendations - Page 41

1. *Establish a specific date for monthly preparation of the premium due reports.*

2. *Establish procedures to age premiums due from the end of the grace period through the date of the premium due report.*

It is not feasible to establish a specific date for the monthly preparation of the premium due report. The premium due report covers a specified period and before the report can be printed, it is necessary to input and reconcile the transactions relative to this period. For example, if the report is to cover the period before May 1, all the transactions must be input. Depending on volume, accuracy, and computer availability, the Division may complete the processing on May 2, May 5, or May 10, etc. Therefore, it is impossible to specify a certain date for printing the report. The

report is automatically printed when the month's transactions are complete.

It is possible to change the date for aging purposes to the date at the end of the grace period. However, the report referred to by the auditors is only used as an indicator and is not used as a basis for cancelling employers. The Division obviously has access to the billing notices and determines from these billing notices the delinquent firms who, after thirty days, are sent a ten-day notice followed by a thirty-day cancellation letter if the premiums are not paid. In addition, since the premium report shows the period covered, it is an easy process to determine the length of time between the end of the grace period and the date of the report.

AUDITOR'S COMMENTS

We do not agree with the division's contention that it is impossible to establish a specific premium due report date. Since the premium due report does cover a specified period, it should be possible to establish a cut-off date at the end of this period. All input after that date would be included in the next premium due report. If earlier dates of the month are not acceptable, the premium due report could be processed on the 30th of each month. All pertinent data should have been received and reconciliations completed by this date.

Computer availability cannot be used as a valid excuse because the Data Processing Bureau will schedule regular computer runs at the request of state agencies.

By having a specific report date, the premium due information provided will be more consistent and therefore more useful to the division.

The premium due report can be a more useful tool if modified to provide accurate and meaningful information. The premium due accounts become delinquent at the end of the grace period and, therefore, aging should begin on this date.

Rather than having to refer back to billing notices and compute the age of each premium due, it would be much simpler to have the information provided automatically and routinely in a premium due report. By having this information readily available in a routine manner, the task of determining which delinquent employers should be the subject of enforcement action would be systemized and simplified.

Exemptions for Corporate Officers

Recommendations - Pages 43 and 44

1. *Comply with present statutory requirements for computing payroll for sole proprietor, partners, and corporate officers, or seek legislation which specifically limits or authorizes the division to limit maximum payroll for such individuals.*

2. *Establish procedures to insure that all changes are uniformly communicated to employers as soon as possible.*

The Division does not completely understand the recommendation of the auditors. Regarding sole proprietors and partners, the auditors state in part in their recommendation, "Comply with present statutory requirements for computing payroll for sole proprietor, partners . . ." Section 92-411, R.C.M.1947, specifically states when sole proprietors and partnerships elect to enroll under the Act that "For premium rate making the insurance carrier shall assume salary or wage of such electing "employee" to be five hundred dollars ($500) per month." Because of this specific statutory provision, the Division can only require premium payments based on $6,000 per year, and it would be unlawful for the Division to do otherwise. Therefore, the Division is "complying with present statutory requirements." However, it is true that the law should be changed because the statutory wage for sole proprietors and partnerships is too low and as the auditors point out, they do not pay their fair share relative to benefits. The Division is going to seek legislation to correct this problem.

The auditors question the Division's position relative to the limitation administratively set for wage reporting on corporate officers, and they believe our policy

is contrary to statutory requirements. They base their position on the language in Section 92-1101, R.C.M.1947. That particular provision has the following phrase:

> ". . . pay to the industrial accident board (division) a premium based on a percentage of his payroll as determined by the industrial accident board (division) which shall be a member of a rating organization. . ."

We feel this phrase grants the Division authority to determine maximums on corporate officer wages. This is especially true because the Division must be a member of a rating organization. The Division almost uniformly follows the rules and guidelines set down by the rating organization. That organization sets a limit of 15,600 on corporate officer salaries. The Division did administratively reduce its initial limitation on corporate officer salaries from $15,600 to $6,000.

The change in corporate salary limitations for premium rate making purposes was enacted in order to put corporate officers on the same basis as sole proprietors and partnerships. The Division, under its rule-making authority in Section 92-208, R.C.M. 1947, adopted a rule allowing corporate officers to exempt themselves from coverage under the Workmen's Compensation Act. The rule was in line with the exemptions found in Section 92-202.1, R.C.M.1947 in which sole proprietors and working members of a partnership are exempted from coverage under the Workmen's Compensation Act unless an election is made.

Both the rule allowing corporate officer exclusion from the Act and the setting of a $6,000 maximum for payroll reporting were adopted to eliminate an unfair situation that existed if a corporation was formed for tax savings or other bona fide business purposes. The Division is of the opinion that the wording in Section 92-1101 and the fact that the Division must belong to a rating organization allows it to adopt the $6,000 salary limitation for corporate officers. However, we will carefully review this subject and request statutory changes where needed.

The Division will adopt procedures to insure that underwriting changes are uniformly communicated to employers. The fact that some corporations do not know of the

$6,000 limitation on payroll for corporate officers and the fact that corporations may be overpaying premiums, will be corrected as annual audits are made of these corporations.

Vacation Pay in Payroll Reports

Recommendation - Page 45

We recommend that the division notify all employers in clear and concise language that vacation pay must be included in the payroll figures reported to the division.

A form letter will be drafted and mailed to all employers advising them that vacation pay must be included in the payroll figures.

Dividends

Recommendation - Page 46

1. *Establish data processing procedures to distinguish between payroll and premium reports which have been received but not paid and those which have been received and paid.*

2. *Establish procedures to preclude the payment of dividends to employers who are in default on premium payments.*

We agree with this recommendation providing the auditors are referring to the premium due and paid for the same base year on which the dividends are calculated. If an employer pays the premium due for the year on which the dividends are based, we believe he is entitled to the dividend even though he may owe premium from a prior or subsequent year or owe more premium for the base year as a result of the audit. In these cases, the dividend is applied to the premium due. We did not have time to review the 97 cases mentioned in the report. However, it appears that in at least 28 cases, the premium due was the result of an audit by the Division field auditors. In these cases, the employer owed more than he had paid either in previous years or in the base year. For example, one employer owed, as a result of an audit, $470.73 for the period of January 1, 1967 through December 31, 1968 which was not the base year. Based on the employer's experience during fiscal year 1972, the base year, the Division calculated a dividend due of $101.98 which was applied to the premium due of $470.73. We believe this is a proper procedure because dividends are a refund of premiums paid during a particular year. We agree that dividends should not be calculated for employers who report premium due in the base period but do not pay the premium. We further agree

that this happened in the past and the problem will be resolved in the new data processing system. However, in our opinion, the $18,393 referred to in the report is significantly overstated because it includes firms who owed additional premium as a result of audit and who owed premiums for years other than the base year.

AUDITOR'S COMMENTS

The divisions "Montana Rules, Classifications and Rates for Workmen's Compensations and Occupational Disease," states the employer may qualify for dividends provided:

> "(a) He is not in default of payment of premium. Premium shall include all normal premiums on payrolls, audit assessments and additional advance deposit premium. Audit premium and advance deposit premium billed at least 30 days prior to the date of distribution shall be considered as current premiums due and must be paid in full before the distribution date."

In our opinion, this rule required, as condition for the payment of dividends, at least the payment of premiums for (1) prior years, (2) the base year, and (3) audit premiums billed at least 30 days prior to the date of distribution. Dividends in these categories constitute $14,525 of the $18,393 dividend payments in question. The remaining $3,868 in dividends were distributed to employers in default in the current year. In this regard, it does not make sense for the division to pay dividends to firms which owe premiums to the division for any period. Especially since, the insurance program operates on a payment after the fact basis, i.e., the insurance coverage has been provided before payment is sought by the division.

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Bad Debt Write Off Procedures

Recommendations - Page 49

1. *The Department of Administration establish procedures to receive account for, and write off balances declared to be uncollectible by state agencies.*

2. *Effective July 1, 1974, the division certify uncollectible balances to the Department of Revenue for collection.*

3. *The division transfer balances to the Department of Administration on a regular basis once those balances are recognized as uncollectible.*

We will work within the rules and procedures established by the Department of Administration and the Department of Revenue to implement these recommendations.

Actuarial Review

Recommendations - Pages 51 and 52

1. *Engage an actuarial firm specializing in workmen's compensation insurance to evaluate the overall actuarial condition of the fund and determine the future actuarial needs of the fund.*

2. *Establish a formal written agreement when engaging an actuary.*

We agree with the concept expressed in this recommendation but to some extent disagree with the implications made in the report. The actuary engaged by the Division recommended increasing certain reserve accounts. At times, this was done verbally, but it is evident that he did evaluate the reserves since the reserve levels have increased over the years. Based on the review of the State Fund for fiscal year 1972-1973, the actuary issued a report which summarized the assets and liabilities of the fund. In this report, the actuary concluded that, ". . . the Fund is operating in a sound actuarial and financial basis." The opinion of the actuary was only qualified to the extent that he relied on the opinion of the auditors that, "the procedures of the Division are adequate to properly establish and maintain the records necessary for this purpose." The actuary provided several other opinions and recommendations in writing based on his review of the fiscal year 1972-1973 opertions. We agree that the actuary did not express his opinion in some formal uniform written language or phrase used by all actuaries and if there is such standard language, we will require the actuary to express his opinions in such a manner. The point is that the actuary reviews

the rates and the experience under each classification, reviews the reserves, anticipates increases in costs, expresses opinions and conclusions, and states his recommendations.

The Division agrees with Recommendation No. 2 and this will be done the next time the Division hires an actuary.

AUDITOR'S COMMENTS

Although the same actuary firm has been retained by the division since January 1, 1971, the first actuarial evaluation of the State Fund was not issued until the early part of 1974. The first complete actuarial report and a related actuary certification came only after our direct inquiries and probes within the division and with the actuary himself. These inquiries were necessary not only to determine what actuarial evaluation had been done by the actuary, but also to determine just what the actuary was supposed to be doing. Initially, the actuary sent the division a very limited report on rates. This report was sent back to the actuary by the division because of errors. The actuary then sent the division a letter which apparently represented the formal evaluation and opinion we were inquiring about. Subsequently, the actuary sent the division a new report which contained an actuarial opinion and certification. The point of the foregoing is that (1) the division apparently did not seek and the actuary did not give a complete and formal actuary report, opinion, and certification until early 1974 even though the actuary had been engaged since 1971, and (2) the 1974 report came only after numerous inquiries by the audit staff.

It is true that the actuary opinion is qualified; however, this is an understatment. The qualification pertains to the ". . . opinion of the auditors that, 'the procedures of the Division are adequate to properly establish and maintain the records necessary for this purpose'." An auditor's opinion of this type is nonexistent for the year in question,

1972-73, and such an opinion is only available for 1968-69. Consequently, the actuary's opinion is conditioned upon an auditor's evaluation and opinion which does not exist.

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ASSESSMENTS

Recommendations - Page 56

1. *Repeal the specific percentage requirements of Sections 92-902 and 1005, R.C.M. 1947.*

2. *Establish statutory authority to recover administrative costs from employers and insurers on the basis of an equitable formula devised and applied in accordance with the Montana Administrative Code.*

We agree with these recommendations and will seek the necessary legislation. Although the Division allocates its costs to Plans I, II and III, the allocation is not used as a basis for the assessments because of the statutory limitation mentioned in the auditors' report. The allocation system is not accurate, as pointed out in the auditors' report, and therefore, it cannot definitely be concluded that Plan III has borne the deficit between expenses and assessments. Because the system used by the Division to allocate expenses needs improvement, it cannot be determined with any finality the relationship between assessments and expenses under Plans I, II, or III.

ALLOCATION OF SALARIES

Recommendation - Page 57 (Safety Bureau)

We recommend that the division allocate all salary costs of the mine unit on the basis of mine inspections.

We agree with this recommendation and will take the necessary steps to correct the problem when we review and establish a new allocation system for fiscal year 1974-75.

Recommendation - Page 58 (Compliance Bureau)

We recommend that the division allocate the cost of employee salaries to the activities which benefit from the employees services.

We agree with this recommendation and the problem should be resolved under the Division's new program structure which will go into effect on July 1, 1974.

DISTRIBUTION OF SALARY COSTS

Recommendation - Page 59 (Compliance Bureau)

We recommend that the division allocate the costs of the Compliance Bureau to only Plans I and II.

This recommendation was implemented in October 1973.

Recommendation - Page 61 (Safety Bureau)

We recommend that the division use direct labor hours of safety inspectors as a basis for allocating the cost of the Safety Bureau to Plans I, II, and III.

Assuming the example used in the auditor's report is representative, we agree that direct labor hours is a more equitable basis for allocating Safety Bureau costs and will take the necessary steps to implement the recommendation when we revise and design a new allocation system.

REPORTING AND PROCESSING OF INDUSTRIAL INJURIES

INDUSTRIAL INJURY REPORTS

Recommendation - Page 68

1. *Establish field examination and other procedures to insure that all injuries are reported as required by Sections 92-807 and 808, R.C.M. 1947.*

2. *Institute routine follow-up procedures for use in those instances where unreported injuries are identified.*

3. *Initiate legal action in those instances where injuries have not been reported and such action is appropriate.*

The legislative auditors' first recommendation is sound. However, no indication is given as to the extent the auditors would suggest the Division should pursue this matter. It would take a large expansion of the Division's audit staff in order to implement a meaningful program of "field examination and other procedures" to insure all injuries are reported. Even with a large increase in field investigations, it would be impossible to formulate a program to assure that all injuries are reported.

The Division agrees with the auditors second recommendation, but it feels it, in fact, has a routine follow-up procedure regarding unreported accidents. However, this procedure must be improved upon and formulated into a methodical step-by-step process.

The auditors' third recommendation that the Division initiate legal action against derelict employers has in fact been done in some instances. The Division will use this means more often in the future when employers refuse to submit reports as required by law.

It should be pointed out that the auditor misstates the law on Page 62 when he states that the "1973 amendments to the law also allow recognition of injuries in the area of cardiovascular, pulmonary, and respiratory disease." Injuries involving cardiovascular pulmonary and respiratory disease have long been recognized in this state under the statutory definition of injury. The 1973 amendments appear to only refer to amend-

ments in the injury definition relating to firemen, and the legislature apparently did not want any implication that the traditional definition of injury would no longer include cardiovascular disease, etc. under the injury definition in the Workmen's Compensation Act.

AUDITOR'S COMMENTS

There is no misstatement of the law. Our only purpose in mentioning the 1973 amendments was to show that the term injury is broadly defined under Montana Law and that the elegibility of cardiovascular, pulmonary, and respiratory disease as injuries was expressly recognized in the statutes by the 1973 amendments.

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EMPLOYER REPORTS

Recommendations - Page 71

1. *Advise all employers of the mandatory reporting requirements and penalties prescribed by Sections 92-808 and 41-1718, R.C.M. 1947, and the Montana Administrative Code.*

2. *Require all employers and insurers to date stamp all injury reports upon receipt from employees, employers and physicians.*

The Division agrees with these recommendations. It will be a fairly simple matter to advise all employers enrolled under Plan III of the mandatory reporting requirements. The Division will seek to have all Plan I employers advised of these recommendations and require all Plan II insurance carriers to advise their insured of these requirements.

The Division does have a system whereby employers who do not submit reports are advised of the legal requirements. If a derelict employer does not submit a report as required and as requested by the State Insurance Fund or the Compliance Bureau, a notice goes to the employer from the Division's legal counsel and ultimately a misdemeanor charge may be requested to be brought against an employer.

We recommend that the division undertake a comprehensive study to determine the reasons why physician reports are excessively delinquent and the alternatives available to remedy the problem.

We agree that immediate submission of an initial report is desirable. This problem has been studied and discussed at length with individual physicians and various committees of the Montana Medical Association.

The problem is that physicians are requested to submit reports by state and federal agencies, liability insurance companies, workmen's compensation, health and accident practicing medicine. These reports cannot ordinarily be completed by an office receptionist or clerk. They require the personal attention of the physician.

The Medical Association recognizes the problem and has recommended the use of a standard reporting form (See Exhibit #3). We have studied this form and discussed it with representatives of the self insurers and private carriers. Further discussion is in progress and a recommendation will be made to the Administrator within a short time.

The auditors apparently are not aware of this comprehensive study.

AUDITOR'S COMMENTS

Upon review of this "comprehensive study" we determined that the division has never issued a formal report discussing findings, recommendations, or results, and that the "comprehensive study" was more or less just an ongoing discussion. The only documentation of this study consists of a small correspondence file maintained by the State Insurance Fund Bureau Chief. The only apparent result of this study appears to be a change in the Attending Physician's Report-Form about 2 years ago. For a comprehensive study which officials advised us has encompassed 6-7 years, the results are quite negligible.

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PROCESSING SYSTEM

Recommendation - Page 78

We recommend that the division modify the Employer's First Report of Occupational Injury or Disease (form 37) to provide for:

(a) Employee acknowledgement of the injury.

(b) Declaration of employee intent/deliberation to file a claim for compensation.

Although combining the employer's and employee's injury report has merit and would certainly reduce the volume of paper processed by the Division, we believe that a second alternative should be considered-----the combining of the employee's and physician's first report of injury.

Combining the employee's and the employer's reports causes some practical problems in that in some industries, the employees of the firm responsible for submitting the employer's report are remote from the injured employee.

It may be difficult and result in further delay if the injured employee is unable to sign the combined report. In addition, this plan was suggested in the past and the insurers and employers questioned whether the employers should be responsible for submitting a claim for an injured employee since the law places the burden on the injured claimant.

Combining the employee's and physician's reports may be a more practical solution in that they are generally in close proximity. In addition, such a plan may have an additional benefit in reducing the physician's reporting time.

Employer Numbers

Recommendation - Page 80

We recommend that the division review the present procedures used to identify and file employer and employee-related records.

We concur with this recommendation and intend to use employer numbers as a means of readily identifying coverage. We do not see a need to control and file all documents by employer number rather than accidents number as is presently being done.

Employer Number Cards

Recommendations - Page 82

1. *Provide all employers with standard identification cards for distribution to employees who have been injured and are entitled to coverage under the various workmen's compensation insurance plans.*

2. *Request employers to instruct injured employees to use these cards when seeking assistance or services under the workmen's compensation insurance program.*

We have discussed the possibility of issuing identification cards at various times in the past. Consideration is still being given to sending such a card along with the Claim for Compensation (The State Fund mails a Claim for Compensation to every injured workman, regardless of the severity of the injury.)

We know from past experience that furnishing such a card to the employer is not feasible. The State Fund for years provided a small form to the employers entitled "Notice to Doctor". We can remember possibly ten or twelve occasions when this form was utilized by an employer over a ten-year period.

Employers are deeply involved in operating a business, hopefully at a profit. Many of them will not devote their time to help administer a social program. Some type of system involving standard identification cards may help, and the Division will consider adopting such a system and a means of instructing employers and employees in using the system.

Processing Procedures

Recommendations - Page 87

1. *Establish a procedure whereby the first step in the processing system is a screening determination of coverage and segregation of documents by Plans I, II, or Plan III.*

2. *Request the National Council on Compensation Insurance to assist in the review and revision of the file and document processing systems currently employed by the Division.*

We agree with these recommendations. We should carry this a step further and do everything possible to have the documents identified by insurer and proper mailing address at the point they originate.

For example, an incoming WATTS line has been installed. We are utilizing it exclusively for hospitals for a sixty to ninety day trial period. It is working well, and we are advised immediately when a workman is hospitalized and as a result, can give better service to the injured man. We in turn advise the hospital where to send the bill. The hospitals like it because they are assured of payment. We hope to make the WATTS line available to other specialized groups in the future. The end result will be that we will reduce the incoming mail load to the Division and the documents that are mailed to us will be identified by plan at their source.

Employee Training

Recommendation - Page 89

1. *Prepare and disseminate written procedures and guidelines governing the duties and responsibilities of all employers.*

2. *Conduct periodic training programs and staff meetings.*

We agree with this audit recommendation. Preparations are now being made to write a new procedure manual for each employee. Also, training sessions are being conducted and staff meetings are being held to inform and update employees on Division procedures as well as policies.

DELIVERY OF COMPENSATION

LUMP SUM SETTLEMENTS

Recommendation - Page 103

1. *Limit the use of lump-sum settlements to those instances where claimants demonstrate that such a settlement is in their best interest from the standpoint of betterment and rehabilitation.*

2. *Specifically document the basis and justifiction for lump-sum settlements as required by Section 92-715, R.C.M. 1947.*

The Division agrees with the legislative auditors' recommendations. However, the Division believes the auditors may have oversimplified this subject. The Workmen's Compensation Act compels settlements under certain circumstances. Under the law, an injured workman who has some type of permanent impairment is entitled to an impairment award even though he is no longer receiving disability payments due to his return to work with no wage loss. Thus, a distinction must be made between cases in which a man is receiving biweekly payments due to a wage loss and payments due only for a physical impairment.

If an individual is receiving compensation payments due to a wage loss, he is in effect on an income maintenance program, and a settlement of such payments should not be made unless a true rehabilitation program is contemplated. However, in an instance where an individual is no longer entitled to biweekly payments because of a return to work at the same or greater salary, the concept that an impairment award entitlement to the individual should be paid out biweekly may lose its validity. The man no longer needs an income maintenance program. There must be a final understanding between the insurer and the claimant as to the amount of the impairment entitlement and thus a "settlement" must be reached. Once the understanding is agreed upon, there is probably no reason to force payments biweekly rather than in a lump sum. However, there are instances when the Division determines that even impairment entitlements should not be paid in a lump sum due to some persons inability to handle their own financial matters.

The legislative auditors cite the case of Laukaitis v. Sisters of Charity, 135 Mont. 469, 342 P.2d 752, when they discuss the propriety of settlements. It should be noted that the Court in its opinion states the there should be no hesitancy in permitting lump sum payments where the best interest of the parties demand it, and the Court concludes that the case is not to be interpreted as holding that lump sum awards are looked at with disfavor under Montana law.

It must also be pointed out that in some instances, lump sum payments are granted for accumulated back compensation. The legislative auditor does not place such settlements into a separate category or make distinctions between the settlement of income maintenance compensation and impairment entitlement awards, but lumps all settlements into one statistic. Thus, the inference that merely because a great number of claims are settled in Montana, the system is bad, may be misleading. With the new changes in administration, specific documention is now required in affidavit form to justify proposals for lump sum settlements.

AUDITOR'S COMMENTS

The division expresses the belief that we are inferring that the system is bad because of the volume of lump-sum settlements. They properly state that the Montana Supreme Court has recognized that lump-sum settlements may be proper under certain circumstances. We do not dispute this conclusion.

However, in the case of Laukaitis v. Sisters of Charity, which the division cites as authority for their position, the court started at p. 472;

> "This court has stated that the intention of the legislature in enacting the Workmen's Compensation Act was that the monthly payment plan provided should be the rule and the lump-sum settlement the exception.
>
> . . .
>
> 'Experience has demonstrated that lump-sum awards should be the exception rather than the rule.'"

And in the later case of Malmedal v. I.A.B., 135 M 544, the Montana Supreme Court stated at p. 558;

"We do comment though, in keeping with our previous decisions, that lump-sum settlements are the exception. Any plan for betterment and rehabilitation should demonstrate some reasonable basis for successful fulfillment of the betterment and rehabilitation features. The burden of proof is on the claimant to show this."

The table on page 96 of the report indicates that 34 percent of all claims settled and 59 percent of all compensation paid from January 1, 1970 through June 30, 1973, were paid as lump-sum settlements. The payment of 59 percent of total compensation as lump-sum settlements can hardly be called an "exception."

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AUTHORITY OF ADMINISTRATOR

Recommendation - Page 110

We recommend that the state insurance program establish procedures whereby all compromise payments and lump-sum payments result from a routine and methodical process of evaluation and decision within the state insurance program.

The Division agrees with this recommendation. The problems created by the fact that the former administrator was directly involved in claims settlement were corrected administratively some time ago. Except in rare instances, the present adminidstrator does not get involved in negotiating settlements or day-to-day handling of claims. A proper delegation of authority has been granted to the State Insurance Fund. The fund handles all the claims processing and negotiates settlements through a claims review committee, and the administrator merely reviews the propriety of settlements from the State Insurance Fund in the same manner that he does for Plans I and II. By law the administrator must approve the final determination in cases involving all three plans.

MEDICAL REVIEW

Recommendations - Page 120

1. *Formulate regulations requiring the impairment aspect of all ultimate settlements be based upon the American Medical Association Guides to the Evaluation of Permanent Impairment.*

2. *Establish a peer review process to routinely review medical reports and other medical activities of the workmen's compensation insurance program.*

3. *Establish a medical review panel to selectively review controversies arising from the peer review process.*

The Division agrees with this recommendation. The Division feels it would be helpful to have a uniform appraoch to medical impairment ratings and the JAMA guides would no doubt be the best guides to follow.

The Division has, in fact, adopted a rule stating that permanent impairments are rateable in percentages and ratings shall be based on the AMA Guide to Evaluation of Permanent Impairments. (See Section 24-3.18(22)-S18100(7), Montana Administrative Code). However, it appears the rule can only be considered advisory in that the Division has no statutory authority to adopt a binding rule regarding impairment ratings. It must be remembered that administrative agencies only have the authority expressly granted to them by law. State v. State Board of Equalization, 133 Mont. 8, 319 P.2d 221. Therefore, the Division should seek specific statutory authority giving it the power to adopt a binding impairment rate schedule.

The Division is already looking into the establishment of a medical review panel and some type of medical peer review process for the review of medical reports, and is Presently working with the Montana Medical Association in this regard.

ATTORNEY SERVICES

Recommendations - Page 129

1. *Establish a fee schedule governing the attorney fees allowable in conjunction with workmen's compensation cases.*

2. *Establish and periodically modify the fee schedule in accordance with the procedures of the Montana Administrative Procedures Act.*

3. *Establish procedures whereby the amount of attorney fees paid are reported and documented in each workmen's compensation case.*

The Division agrees with the legislative auditor on this recommendation. However, the Division feels it must have specific statutory authority in order to carry out the recommendations, and in fact, the Division did seek legislation in the recent session to give it authority to do exactly what the legislative auditors recommend.

The legislative auditors feel the Division has authority to regulate or set attorney fees on all workmen's compensation claims and cite two sections in the Workmen's Compensation Act and a Sumpreme Court case in order to justify that position. The authorities cited have no application to claims that have not gone to formal hearing before the Division on some disputed question.

The legislative auditors quote a paragraph out of Section 92-827, R.C.M.1947, upon which they base their contention. The quoted material is found in a lengthy section that deals exclusively with contested case hearings. The provision quoted by the auditors is the second paragraph of a section containing six paragraphs pertaining to hearings and appeals to courts. The first paragraph requires a full and complete record to be kept at hearings had "before the board." The third paragraph states that on all actions to review a decision of the board, the transcript, pleading and exhibits, etc. constitute the record, and the record must be furnished to the claimant without cost. The fourth, fifth, and sixth paragraphs relate to appeals to district courts from hearings before the Division. Thus, the entire section relates to the hearings process. The section is found in Chapter eight of the Workmen's Compensation Act and Chapter eight pertains almost exclusively to the mechanics of formal contested case hearing procedures before the Division and appeals to the District and Supreme Court.

The language in paragraph two of the section as cited by the legislative auditors uses the term "either before the board or the courts." That term denotes a hearings process in that no workmen's compensation case comes "before a court" unless it is formally contested. Courts have nothing whatsoever to do with the bulk of workmen's comp-

ensation claims that are never contested. The term "before" in the sentence relates to both the board and a court and the sections can only mean an adjudicatory proceeding before the "board" and not the general day-to-day administrative detail conducted on all workmen's compensation claims by the Division. It is also significant that in the first paragraph of Section 92-827, the term "before the board" is used in the following manner: "A full and complete record shall be kept of all proceedings and hearings had before the board, . . ." Thus, any attempt to interpret the provision in Section 92-827 relating to the setting of attorney fees as allowing the Division to set fees on all workmen's compensation claims is invalid in that such a contention completely ignores the context in which the section was written, the specific wording used in the section, and the fact that the section is found within the chapter of the Workmen's Compensation Act which deals almost exclusively with contested case hearings before the Division and appeals to courts.

The legislative auditors attempt to justify their position by quoting a phrase in the case of In Re Porter, 156 Mont. 190, 478 P.2d 866. The case in fact substantiates the position of the Division in that the case pertains to a workmen's compensation claim that went to a formal hearing held "before the board" under the provisions of Chapter eight in the Workmen's Compensation Act. Subsequent to the hearing, formal findings of fact and conclusions of law were written in which the hearings officer set an attorney fee. The Supreme Court indicates in its opinion that it was not going to go through the detailed process of "setting forth a complete fact statement" of the case. The Court had the record of the workmen's compensation claim before it including the record of the formal contested case hearing held before the Board as well as the findings of fact and conclusions of law which among other things set the attorney fee. The court then merely noted that under such circumstances, Section 92-827, R.C.M.1947, grants the power to the Board to set an attorney fee.

Also, the legislative auditors cite Section 92-616, R.C.M.1947, apparently in some

attempt to justify the position that the Division has authority to set attorney fees on all workmen's compensation claims. One merely has to read the auditor's paraphrase of the section to see that it only applies to cases involving hearings and only to hearings on very specific factual situations; namely, on denial and termination of claims later adjudged compensable. The applicable words in the section are "and the claim is later adjudged compensable, by the division or on appeal, the insurer shall pay reasonable costs and attorney fees as established by the Division." The only time the Division can "adjudge" a claim compensable is after a contested case hearing. The plain meaning of the language in the section could dictate no other interpretation.

AUDITOR'S COMMENTS

Although we believe that the division presently has the authority to regulate attorney's fees, the division has not and does not so interpret their authority. The division states that attorney fees should be regulated. The division should therefore seek such additional statutory authority as they believe necessary to regulate attorney's fees.

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PRESENT WORTH ADJUSTMENT

Recommendation - Page 131

We recommend that the division apply the present worth adjustment to all lump-sum payments as required by Section 92-715, R.C.M. 1947.

The Division agrees with this recommendation and in fact, it is now doing so. The Montana Supreme Court held recently in the case of Kuehn V. National Farmers Union Property and Casualty Co., 31 State Reporter 375, that the Division was in error when it did not convert a lump sum advance to estimated present worth capitalized at 2% as required by statute. On May 23, 1974, the Division sent a memorandum to all workmen's compensation adjusters outlining when the discount would be applied on all future cases on conversion of future biweekly payments into lump sum awards. Also, the Division has recently explained the discount procedure to recent workmen's compensation workshop meetings held in several cities in the state, and the Division is now applying the discount in appropriate cases.

PAYMENT OF DISABILITY CLAIMS

Recommendation - Page 133

We recommend that the division in consultation with the Department of Administration take the measures necessary to pay compensation benefits through the state/claim warrant system.

We are unable to comply with this recommendation because the present state claim warrant system cannot provide the services needed. A new system would have to be designed, interfaced with the state claim warrant system, and would necessarily duplicate much of the same information input to our own system for other purposes. We do not believe it is economically justifiable or necessary to design programs and implement a system for the sole prupose of writing compensation warrants on the state system and mailing the warrants from the State Auditor's office. Such a system would have to provide a daily print out prelisting the claimants who are to receive compensation payments within the next two days. A special all purpose (AP) warrant would have to include the name and address of the claimant because it would not be feasible to prepare warrant-transmittals for the 60 to 100 warrants written each day. A check stub and carbon copy would

have to include the claim number, class code, employer, period covered, etc. because this information is needed to update our accounting and statistical information maintained on our own system. A warrant writing system designed to "mechanically and routinely produce warrants" would have to store this same information which duplicates the information stored in our data processing system. A better procedure would be to mechanically produce the warrants through our data processing system so that the same files can be used. This will be discussed later in this response.

The audit report expresses no sound basis or reason for using the state claim warrant system to print the warrants. The report refers to programs being designed to bring the Employment Security Division (ESD) and the Department of Social and Rehabilitation Services (SRS) into the state claim warrant system. We were advised by ESD that the only changes contemplated in their system is to mechanically produce the warrants with their computer. ESD will still pick up, sign, and mail the warrants. Neither ESD nor the Department of Administration is aware of any program being designed to include ESD into the state claim warrant system. We informed the legislative auditors of that fact at the exit conference and requested information as to the nature of the ESD system referred to in the report and who was designing the system.

SRS is planning to implement a system but their needs and the needs of the Division are entirely different. We were advised by SRS that their system will produce warrants once a month as opposed to daily and require the information to be input to the computer five to eight days before the warrants are printed. Our needs require a much faster turn around. We were also advised that the system will cost around $200,000 to implement.

The audit report states that there were "some weaknesses" in internal control but we are unable to comment on these weaknesses nor institute the necessary correction procedures until the auditor specifies what weaknesses were uncovered as a result of the audit.

The report specifies that the primary objection to placing payments on the state claim warrant system was because the system could not make payments soon enough. The auditors conclude that this objection is no longer valid because improvements have been made. We are unaware of the improvements referred to by the auditors nor the methods they used to test whether these improvements have increased the claim warrant turn-around-time to a degree sufficient to meet our needs. We believe the objection is still valid and given time can show many examples where payments were delayed in the system. Such delays are understandable since the agency, accounting bureau, data processing bureau and the State Auditors Office are all involved in the processing of a claim. Minor delays in the payments of claims are not as critical in the normal course of the state's business. However, delays in payment of workmen's compensation warrants result in an injured employee waiting for his check which may be a major source of funds for his livelihood. Such delays should be avoided if possible and establishing a warrant writing system which is not under the direct control of the Division does not, in our view, represent the best method of solving any internal control problems. The report suggests a system similar to central payroll. In order for central payroll to process the state

payroll, it is necessary to submit the payroll documents one week in advance. Such a system would not assist the operations of the Division.

The report states that more than one half of the payments involve "fixed liability" claims and that these could readily be put on the state claim warrant system. Although emergency situations arise requiring immediate response even in fixed liability cases, the auditors admit that only more than half of the payments are of this type. Since the Division processes over 20,000 warrants a year, it appears that we would to establish a system to directly process the issuing of at least 10,000 warrants much in the same manner as presently being done. Two systems, i.e. the state claim warrant system and direct processing hardly seems justified in order to pay compensation to injured employees.

Basically, the entire section of the report deals with one function in the payment of a compensation, i.e. the printing and mailing of the state warrants. The accounting transactions are presently entered in summary form to the Statewide Budgeting and Accounting System and also in detail to our own system. The funds used to pay the warrants are within the Treasure Fund Structure and controlled and recorded by the State Treasurer. We are not writing checks outside the state accounting system on a private bank account. The Division is designing a new data processing system which will assist all facets of the Division's operations. As a part of this system, we are considering the mechanical writing of state warrants which resolves some of the auditors' objections to our present methods, eliminating duplicate computer files, and facilitating the printing of the warrant and inputting the accounting data into one process.

We believe such a procedure is a better alternative to desiging a separate system to interface with the present claim warrant system. It provides direct control to minimize turn-around-time, and it should enable us to respond immediately to emergency situations.

AUDITOR'S COMMENTS

By the admission of the division, at least half of the compensation payments made by the division are for "fixed liability payments." Another portion of the compensation checks issued are for lump-sum payments where the bi-weekly payment requirement need not be met. In these two types of payments the present turn around time of the state claim-warrant process (24-48 hours) should be sufficient. In the remaining cases the division could prepare multiple vendor transfer warrant claims and deliver them to the accounting bureau by messenger rather than deadhead mail. An accounting bureau official stated that so long as they could depend on the division to properly code the claims he could give them, as a matter of routine, special priority to speed up the key punch and check printing process. According to officials at the State Auditor's Office the checks would be mailed the same day they received them. Here again the checks could be given special priority.

It would appear that with concentrated effort on the part of the division, the accounting bureau, data processing, and the State Auditor's Office, the problems with using the claim warrant process could be overcome. The internal control weaknesses discussed at the exit conference would be solved and other benefits would accrue. First of all, the agencies statutorily authorized and set up to perform the administrative services of printing, accounting for, mailing and storing warrants would perform the services rather than the division whose responsibilities are much broader. Secondly, warrants negotiated by claimants and cancelled by the state would be placed in a secure repository under the custody of the State Auditor, along with all other state warrants. This repository would preclude the loss or misplacement of warrants which are the ultimate proof of payment and which are often crucial in matters of litigation.

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AGENCY ORGANIZATION

Recommendation - Page 141 and 142

We recommend that legislation be enacted to:

1. *Organizationally separate the state insurance program from the present Workmen's Compensation Division and establish it as a separate entity within the Department of Labor and Industry.*

2. *Vest the remaining organizational units of the Workmen's Compensation Division with the power, authority, and responsibility to administer and enforce the workmen's compensation laws in the areas of coverage, compliance, safety, and adjudication of appeals.*

We very strongly disagree with these recommendations. The audit report correctly identifies a conflict of interest problem on Page 136. This conflict was recognized some time ago by the Governor's Office and the Office of Executive Reorganization. However, their recommended solution was the separation of the contested case hearings function of the Division rather than separation of the State Insurance Fund. The result was the introduction of House Bill No. 294 in the 1973 legislature which would have designated the Board of Labor Appeals to hear appeals on disputed workmen's compensation cases.

The problem was also considered at length during the interim between the 1973 and 1974 sessions by the Division, the administration, and various interested groups. There appeared to be consensus of opinion that the quasi judicial functions of the Division should be transferred to remove the statutory conflict of interest. However, rather than transfer the functions to the existing Board of Labor Appeals, it was generally felt that a new board should be created which would hear all disputes concerning benefits under the Workmen's Compensation and Occupational Disease Acts. In line with this thinking, a draft of proposed amendments to HB 294 was submitted to the Senate Committee on Executive Reorganization for its consideration. Below are the appropriate provisions submitted to the legislature regarding the creation of a new board of workmen's compensation appeals, its functions, and the repeal of the Division's present statutory authority to hear disputed cases.

"Section 1. There is a new section to be numbered 82A-1015, R.C.M.1947, which reads as follows:

82A-1015. Board of workmen's compensation appeals--creation, allocation; composition; designation. (1) There is created a board of workmen's compensation appeals.

(2) The board is allocated to the department of labor and industry for administrative purposes only as prescribed in section 82A-108.

(3) The board consists of three (3) members appointed by the governor as prescribed in section 82A-112. In selecting members for the board, the governor should give due consideration to individuals who are knowledgeable in workmen's compensation law. The chairman of the board shall devote full time to the duties of the board, and he shall be a full time salaried officer of the state. The chairman may call upon the other members of the board to assist in the conduct of hearings for the board, and the provisions of section 82A-112(7) do not apply to members of the board. Expenses of the board shall be paid upon appropriation from the workmen's compensation earmarked revenue account.

(4) The board is designated as a quasi judicial board for the purposes of section 82A-112.

Section 2. There is a new section to be numbered 92-844, R.C.M.1947, which reads as follows:

92-844. Appeals. (1) A claimant, compensation plan one employer, or insurer who has a dispute concerning any benefits under title 92, R.C.M.1947, is entitled to appeal to the board of workmen's compensation appeals provided for in section 82A-1015. The board, after a hearing, shall make a final determination of the dispute, and in accordance with the law on benefits as set forth in title 92, the board shall fix and determine such benefits to be paid, and specify the manner of payment.

(2) The board may grant nominal disability awards in cases where it is found that an accident has occurred in the course and scope of employment, but no disability has resulted therefrom.

(3) The board has continuing jurisdiction of cases it has made determinations on, and it may upon the application of any part, review, diminish, or increase in accordance with the law on benefits as set forth in title 92, any benefits awarded, upon the grounds that the disability of the person has changed.

Section 3. There is a new section to be numbered 92-850, R.C.M.1947, which reads as follows:

92-845. Administrative procedure act. All proceedings and hearings before the board of workmen's compensation appeals, and all appeals to the courts of this state from decisions of the board, shall be in accordance with the appropriate provisions of the Montana administrative procedure act. However, the board is not bound by the technical rules of evidence.

Section 4. Sections 82A-1004, 82A-1005, 92-812, 92-813, 92-815 through 92-817, 92-819, 92-821, 92-823, 92-824, 92-825, 92-827 through 92-836, 92-1347, 92-1350, 92-1351, 92-1353 through 92-1355, 92-1357, 92-1359, 92-1361 through 92-1365, R.C.M.1947 are repealed."

Since the proposal was considered by the legislative committee in the waning days of the legislature, the committee felt it should be held over for consideration by the

legislative interim committee studying the workmen's compensation system in Montana. There appeared to be a substantial amount of support for the Division proposal regarding the transfer of the Division's quasi judicial powers to a newly created board of workmen's compensation appeals, and we submit that this proposal is the most desirable solution to the conflict of interest problem.

We feel that separation of the appeals function is far preferable to separation of the insurance program for several major reasons:

1. Cost to the employer.

   We estimate the cost to the employer of establishing a separate state insurance program to be nearly ten times that of the cost of a separate appeals board.

2. Competition with Private Insurance Carriers.

   We feel it is imperative that the committee and the legislature be aware that, if a separate state insurance program is established as suggested in the report, it will place the State in direct and open competition with private insurance carriers. While we certainly feel that the State Fund should endeavor to offer coverage at competitive rates, we also prefer to maintain the current posture of offering alternative coverage to the employers.

3. Treatment of claimants.

   We suggest that, were the state insurance program to be separated and no longer directly subject to policy direction from the Division, the social concern which is presently inherent in the adjustment of claims would very naturally be eroded due to the competitive posture which would inevitably follow such an organizational arrangement.

Furthermore, we categorically deny that any problems revealed by the report would automatically be resolved by separation of the state insurance program, with the single exception of the conflict of interest matter which has already been discussed. On the contrary, such problems are being resolved by proper internal organization and a revamping of policies and procedures within the Division, all at little or no additional cost to the employer. Some of the problems noted can only be resolved by additional staff, however, and requests will be made through appropriate budgetary channels to the 1975 legislative assembly. In the meantime, the personnel of the Division are working

very earnestly to correct the problems noted wherever possible, and in fact, many of the recommendations have already been adopted and the accompanying problems have largely been resolved.

AUDITOR'S COMMENTS

The division disagrees with us and the Department of Labor and Industry regarding the proposed organizational structure for administering Workmen's Compensation matters.

The division wants to maintain the status quo except for establishing and Appeals Board for handling contested cases.

The Department of Labor and Industry agrees with us that the state insurance program and the regulatory functions should be separated. However, the department believes the division (regulatory function) should be directly under its control and not attached for administrative purposes only as we propose. The department also believes an Appeals Board should be established.

Under the present organizational structure two areas of potential conflict of interest exist. One, around which most of the discussion centers, evolves from the fact that the division is administrator and also adjudicator for Plan III claims. Secondly, the division is responsible for enforcing Workmen's Compensation laws for all plans in a fair and equitable manner. This may be impossible since the division is also administrator for Plan III and cannot deal in an arms-length manner.

In the first instance, regarding the potential conflict of interest relating to being both administrator and adjudicator, the following points should be considered.

a) There presently exists a proper organizational separation between administration and adjudication for Plans I and II. All Plan I and II actions are subject to review by the division, disputed matters are

settled through a hearing process, and finally if necessary, access to the courts is available in those cases where an agreement cannot be reached.

b) In contrast, separation does not exist with respect to Plan III. If the state insurance program (Plan III) was organizationally separated from the division an appeals function similar to Plans I and II would be established.

c) If an Appeals Board is set up, additional costs would be incurred since a separate new organization would be created having requirements for personnel, files, etc.

In the second instance, the potential conflict centers on the ability of the division to treat all plans equally when it also directly administers Plan III. The following should be considered:

a) To insure fair and impartial treatment for all Plans, an "arms-length" basis must be established. This is why we are recommending that the division remain attached to the department for administrative purposes only, rather than being subject to direct supervision of the department. As such, the administrators of the division and the insurance program would be organizationally accountable only to the Governor.

The division expresses the belief that the separation of the insurance program would erode the social concern which is presently inherent in their adjustment of Plan III claims. Contrary to the division's assertion, claimants (injured workmen) would ultimately benefit through separation of the regulatory and insurance functions. The division's statement infers that claimants under the state insurance program fare better than other claimants. This is in itself an injustice to injured employees who have little, if any, control over the plan chosen by their employers. An arms-length

relationship with all plans would insure that injured employees receive fair treatment and consideration irrespective of the plan involved.

b) The separation of the state insurance program would not alter the present relationship of the state to private insurance carriers. Regardless of how the present situation is viewed, the state insurance program is in competition with private carriers, in fact, that is why the state is considered and referred to as a "Competitive Fund State." The use of "experience rating" and "volume discounts," which we recommend and the division has agreed to implement, will make the state insurance program much more competitive. This will occur whether or not the state insurance program is separated from the division. The state insurance program would continue as an alternative source of coverage. Complete, direct and open competition would come about only if a sales force was established for promoting state insurance. This has not been done in the past and there would ostensibly be no reason to do so in the future.

c) There are advantages in having a separate competitive state insurance program. It serves as a "yardstick" with which to measure private carriers and vice-versa. Every competitive fund state except Montana has separate regulatory and insurance functions.

State of Montana

Department of Labor and Industry

449-3472
Helena, 59601

THOMAS L. JUDGE
GOVERNOR OF MONTANA

SIDNEY T. SMITH
LABOR COMMISSIONER

June 6, 1974

Morris L. Brusett
Legislative Auditor
State Capitol
Helena, Montana 59601

[illegible] 1974
[illegible] AUDITOR

Dear Mr. Brusett:

I have studied your final report on the review of the Workmen's Compensation operations dealing with agency organization recommendations. The final report differs somewhat from our previous discussions, so I will make my suggested recommendation on the final report.

The only portion of the report that I have reviewed is that dealing with the organization of the division.

I agree that there is need for reorganization along the lines suggested, that the Insurance Fund should be a separate division within the Department of Labor and Industry, also that a separate division administrate functions of the Workmen's Compensation within the Department of Labor and Industry.

I differ with your recommendation that the Workmen's Compensation Division be attached for administrative purposes only. This independence is partly responsible for the past problems.

The Executive Reorganization Committee set up to reorganize the State into twenty (20) Departments, directed by Professor Duke Crowley, found the conflict of interest referred to in your report. Mr. Crowley, his staff, and myself with others, studied Workmen's Compensation Departments and Industrial Accident Boards in other States to find the best operation to resolve this conflict of one administrator responsible for all functions.

The result of our study was that recommended by Governor Judge in his state of the State message to the legislature. That the Department of Labor and Industry be reorganized to avoid such a conflict of interest and to attain better control of the division. House Bill 294 was introduced at the administrations request. It passed the house, but was held over in the Senate and not acted on this last session due to the investigation of the Workmen's Compensation Division.

House Bill 294, in effect, transfers the functions of the division to the Department of Labor and Industry, permitting reorganization administratively. The Insurance Fund Division and the Workmen's Compensation Division could be completely separate in two (2) divisions. House Bill 294 also set up an appeals board that I feel is needed to properly protect the interest of the worker regardless of coverage under Plan I, II, or III. Your recommendation has partly removed the conflict, but you have left the door open for the possibility of a reoccurance of the problems revealed by your investigation. Special interests or persons must never again be allowed to abuse the workers' compensation insurance program for self gain at the expense of the injured worker.

Sincerely,

Sidney T. Smith

SIDNEY T. SMITH, COMMISSIONER
DEPARTMENT OF LABOR & INDUSTRY